Developmental Disabilities Waiver Manual

Comprehensive, Community Support, Autism Lopez, and Partnership for Hope Waiver Manual

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Introduction to Medicaid Waivers in Missouri

The Missouri Department of Mental Health's Division of Developmental Disabilities (Division of DD) administers five Medicaid Home and Community Based (HCB) Waiver programs for individuals with developmental disabilities. The five waivers are the Comprehensive Waiver; Missouri Children with Developmental Disabilities Waiver (Lopez); Community Support Waiver; Partnership for Hope Waiver (PfH); and Autism Waiver.

Authority for the Division of DD Waivers is the result of a federal law enacted by Congress in 1981 that added a new section to the Social Security Act in 1915(c). Under Home and Community-based waivers, a state may use Medicaid funding for home and community-based services provided only to a target group of people who have intellectual and developmental disabilities and whose care needs would otherwise require services in an institution. Federal law also allows a state to target services by geographic region. The Division of DD uses general revenue funds and local county dollars to match federal dollars to pay for HCB waiver services.

Section A: Eligibility and Planning

Eligibility

An individual must meet the following eligibility requirements to be eligible for any waiver services that the state of Missouri operates.

The ICF/MR Level of Care requires the presence of developmental disabilities as defined in federal rule (42 CFR 435.1010) as:

Persons with related condition as follows: Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:
(a) It is attributed to—

(1) Cerebral palsy or epilepsy; or
(2) Any other condition, other than mental illness, found to be closely related to developmental disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services similar to those required for these persons;

(b) It is manifested before the person reaches age 22;
(c) It is likely to continue indefinitely;
(d) It results in substantial functional limitations in three or more of the following areas of major life activity:
(1) Self-care;
(2) Understanding and use of language;
(3) Learning;
(4) Mobility;
(5) Self-direction;
(6) Capacity for independent living, plus a need for the level of care provided in an ICF/DD.

In addition, a determination must be made that the individual is at risk of needing ICF/DD institutional services if unable to access waiver services. To access waiver services, Medicaid eligible applicants must first be determined eligible for Division of DD regional office services through an assessment process. The assessment includes the Missouri Critical Adaptive Behavior Inventory (MOCABI) for adults or the Vineland or other age appropriate instrument(s) for children. Observations, interviews and collateral information are also used. Once eligibility for Division of DD services is determined, a service coordinator uses the gathered information and any other information needed to evaluate the applicant's eligibility for the Division of DD waiver program.

In addition to the criteria listed above each waiver has specific eligibility criterion that must be met to participate in the specific waiver as specified below.

Special Documentation Requirements

The documents discussed in this section are required for Division of DD Waiver services compliance.

Evaluation of Need for ICF/DD Level of Care and Eligibility for the Developmental Disabilities Waiver:

Before a person enters the Developmental Disabilities Waiver, a service coordinator employed by a Division of DD regional office, or approved County SB-40 Board or other Not-for-Profit Targeted Case Management (TCM) entity that contracts with Division of DD to provide TCM services, gathers collateral information and assures that social history and medical information is current. The service coordinator also ensures that results of any testing or previous habilitative program experience are summarized, and that any additional professional assessment necessary for determining level of care or individual planning is requested. The service coordinator then completes a functional screening instrument designed to provide general information on what a person with developmental disabilities can and cannot do and lists any types of adaptations and supports which are in use.

The MOCABI is the instrument used for adults and for older children, when appropriate. Other age appropriate instruments, such as the Vineland, may be used for younger children. Based on the MOCABI, Vineland or other appropriate instrument, and on observation, interviews, collateral information and assessments, the service coordinator documents on the Evaluation of Need for ICF/DD Level of Care Form:

- That the individual has developmental disabilities and/or a disability that meets the federal definition of a "related condition;"
- That the individual has limitations, which if not for Home and Community Based Waiver services, may require active treatment in an ICF/DD; and
- Why the individual is at risk of entering an ICF/DD;
- Based on the results documented on this form, the individual may be determined eligible for waiver services;
- Only service coordinators employed by a regional office, approved County SB-40 Boards, and other Not-for-Profit TCM entities contracting with Division of DD, have authority to evaluate ICF/DD level of care for the Developmental Disabilities Waivers. All level of care evaluations must be administratively approved through a regional office.

Re-evaluation of Level of Care

Service coordinators associated with the TCM entities described above shall re-evaluate each individual annually for continued eligibility for Developmental Disabilities Waiver services, which includes continued need for an ICF/ DD level of care. The re-evaluation includes the reviewing and/or updating all assessments on which the previous evaluation was based, including the MOCABI, and re-documentation of conditions of eligibility as listed above. Ensuring the re-evaluation is done annually and maintaining copies of the initial evaluation, all assessments and subsequent reevaluations, is the responsibility of the DD TCM entity.

Functional Assessment and Individual Service Plan

No later than 30 days from the date of acceptance into waiver services, the individual and his or her planning team develops an Individual Service Plan (ISP). The Person-Centered Planning process is implemented to develop the ISP, facilitated by the service coordinator. The ISP is in accordance with Division of DD's Certification Principles. The ISP is based on functional assessment, all other assessments that are pertinent, and the observations and information gathered including members of the interdisciplinary team. The functional assessment includes but may not be limited to identifying:

- How the individual wants to live;
- The individual's functional skills and abilities;
- The individual's routines;
- What works for the individual and what does not;
- What the individual wants to learn and how the individual learns best;
- What may interfere with what the individual wants;
- Suggests ways the individual's needs and wants can be met.

The ISP describes how the individual chooses to live his or her life, and how he or she wants to learn. The ISP specifies all the services and supports that are needed, and who is to provide them. Providing supports or making adaptations to the environment may be part of the ISP. The ISP also specifies any possible limitations/challenges the planning team may foresee (and how these limitations may be overcome) to support the person to achieve the individual's desired outcomes. Such limitations can be financial, temporal and/or can relate to health and safety.

If the individual already has an ISP, the planning team updates that plan.

The planning team includes the individual and his or her representative(s), family or guardian. The individual chooses whom he or she wants to attend as a member of the team, unless the individual is a minor or has been judged incompetent, in which case the family or guardian must attend. The team also includes a service coordinator and providers selected by the individual. Other professionals involved with the individual may be included as applicable and at the individual's or their representative's invitation. The service coordinator and the individual and/or his or her representative sign the completed ISP. All members of the planning team are provided a copy of the completed plan as appropriate. ISPs must be approved by the Division of DD. The effective date of the ISP is determined, and shall be no earlier than the date of the planning meeting.

Service contractors are selected by the individual or his or her family or guardian. The contractor shall provide services in support of each individual's ISP based on a person-centered planning process and approved by the regional office. The contractor shall be given a service authorization specifying the services on the ISP for which they are responsible. The contractor may be given a copy of the ISP at the discretion of the regional office.

Prior Authorization

Before delivering any Developmental Disabilities Waiver service, the provider must receive prior authorization approval from the DD regional office. The Division of DD has an automated prior authorization and billing system. The DD Waiver service provider can use a compatible personal computer and modem to link to the regional office billing system. Once linked, the provider is able to view a screen that authorizes the specific service, rate and quantity the provider is approved to deliver for a specific period for each individual that they have been approved by the regional office to serve. Waiver providers are given access to the automated system and instructions on its use by the regional office.

Service Authorization

The Service Authorization is an automated document derived from and supported by the ISP. Division of DD regional offices use an automated system that allows service coordinators to request services identified through the ISP. Administrative staff of the regional offices approves the services on-line. A computer printout of the service authorization can be generated by the regional office as needed. The automated system that creates the service authorization has edits to ensure data integrity such as correct dates and mathematical calculations.

The service authorization, which is subject to federal, MO HealthNet Program Operations, Missouri Medicaid Audit and Compliance Unit (MMAC) and Department of Mental Health (DMH) audit, specifies the following:

- Units of service by month;
- Period of service;
- Provider of each service;
- Total cost of the plan; and
- Approval by the regional offices.

Medicaid Waiver, Provider, and Services Choice Statement

When it is determined that a person needs the level of care provided in an ICF/ DD, the service coordinator informs the person or a legal guardian of any feasible alternatives available under the waiver and gives the person the choice of either institutional or home and community-based waiver services. If the individual or legal guardian chooses to participate in the waiver, a Medicaid Waiver, Provider, and Services Choice Statement must be signed prior to entry into Developmental Disabilities Waiver services. Ensuring the choice statement is completed and the document is maintained is the responsibility of the entity that is providing service coordination.

This choice form also provides, for applicable services, the option for the individual to self-direct all or some of their Developmental Disabilities Waiver services.

When more than one provider of service is enrolled as a Developmental Disabilities Waiver provider for a particular geographic area, the individual or legal guardian must be given a choice among those providers. The Medicaid Waiver, Provider, and Services Choice Statement are used for this purpose. Choice among providers may be limited only if a person's needs are so highly specialized that only an equally highly specialized provider can meet those needs. The limitation must be noted in the individual's record. The entity that is providing service coordination is responsible for ensuring Medicaid Waiver, Provider, and Services Choice Statement are obtained and are maintained in the individual's case record.

Individual Rights to Due Process

Medicaid rights of due process are extended to persons who participate in the Developmental Disabilities Waivers. Individuals have the right to appeal anytime adverse decisions are made or actions are taken. Some examples of adverse action that may be appealed include the individual:

- Is denied participation in the waiver;
- Requests a waiver service but authorization is denied;
- Is determined no longer eligible for the waiver; or
- Has services or units of service reduced without written approval of the individual or guardian.

When adverse action is necessary such as termination, reduction of services, suspension of services, etc., the service coordinator employed by the Division of DD regional office or TCM entity is responsible for notifying the individual in writing at least 10 days prior to any action being taken. Individuals have appeal rights through the Department of Mental Health and Department of Social Services (DSS), MO HealthNet Division. While not required to do so, Division of DD Waiver participants are encouraged to begin with the Department of Mental Health's appeal process. The individual may, however, appeal to the MO HealthNet Division, before, during and after exhausting the Department of Mental Health process. However, once the individual begins the appeal process with the DSS, all appeal rights with the Department of Mental Health end since any decision by the single State Medicaid Agency would supersede a decision by Department of Mental Health.

The individual is informed of the appeal process in the written notice. If the adverse action concerns termination or reduction of services, the individual may request the disputed service(s) be continued until the hearing is held and a decision is made on the appeal. If the result of the agency's decision is upheld, the participant may be required to pay for the continued services. If the agency's decision is overturned, the participant is not responsible for the cost of services. Copies of written notices of adverse action and requests for a Fair Hearing are kept in the individual's record maintained by the regional office or TCM entity.

Individuals are provided information on rights upon entry to the waiver and annually during the person centered planning process. The division has a brochure individuals are given by service coordinators. In addition, information is posted on the division's web-site.

Comprehensive Waiver

To be eligible for the Comprehensive Waiver an individual must:

- Be eligible for Medicaid as determined by Division of Family supports under an eligibility category that provided for Federal Financial Participation (FFP);
- Be determined by regional office to have a developmental disability as defined by Section 630.00 5 (9) of RSMO, 1994; and
- Be determined by the regional office initially and annually thereafter to require an ICF/DD level of care;
- Waiver eligibility must be re-determined at least annually.

Community Support Waiver

To be eligible for the Community Support Waiver an individual must:

- Be eligible for Medicaid as determined by Division of Family supports under an eligibility category that provided for Federal Financial Participation (FFP);
- Be determined by regional office to have a developmental disability as defined by Section 630.00 5 (9) of RSMO, 1994;
- Be determined by the regional office initially and annually thereafter to require an ICF/DD level of care;
- Have needs that can be met within the waiver cap of $22,000.
- Waiver eligibility must be re-determined at least annually.

Missouri Children with Developmental Disabilities (Sarah Jian Lopez) Waiver

In order to be considered for participation in the Lopez Waiver, the child must:

- Be eligible for and receiving Division of DD services (have a developmental disability as defined by RSMo 630.005 (9) (1994).);
- Be living at home and cannot be in placement;
- Be under the age of 18;
- Have a need for developmental habilitation (require significant behavioral/habilitation services and/or family supports available as waiver services) and must need and use at least one waiver service monthly;
- Not be eligible for any regular MO HealthNet programs; or if MO HealthNet eligible, it would only be after meeting a significant spend down;
- Maintain private health insurance. Private insurance must be billed first for coverable services before Medicaid will consider charges. Private insurance will not be billed when Lopez waiver services are provided;
- Require an ICF/DD level of care and be at risk of entering an ICF/DD facility if not provided services under the waiver;
- Waiver eligibility must be re-determined at least annually.

It must also be determined:

- That maintaining the child at home rather than in placement, is both safe and economical (cost less than the equivalent level of care in an ICF/DD).
- If other agencies (First Steps, local school districts) are serving or have primary responsibility for providing formal paid supports to the child or
- If the child is eligible for other state plan MO HealthNet services (such as those provided under the Bureau of Special Health Care Needs (BSHCN) that would meet the child's needs). If these services do not meet the child's needs (provide an adequate level of services and/or the appropriate type of services), then waiver services may be considered.

Autism Waiver

For an individual to be eligible for the Autism Waiver the individual must:

- Be between the ages of 3 to 19 years of age;
- Live with his/her family in the community;
- Have a diagnosis of Autism Spectrum Disorder (ASD) as defined in the most recent edition of the Diagnostic and Statistics Manual of Mental Disorders, American Psychiatric Association. The diagnosis must be made by a qualified professional;

Approved screening/diagnostic tools include:

  - CARS - Childhood Autism Rating Scale,
  - GARS - Gilliam Autism Rating Scale,
  - M-CHAT - Modified Checklist for Autism in Toddlers,
  - PDDST-II - Pervasive Developmental Disorders Screening Test, Second Edition,
  - ADOS - Autism Diagnostic Observation Scale Interview, Revised Generic and Autism Diagnostic Interview, Revised,
  - ADI - Autism Diagnostic Interview, Revised, or
  - ASDS - Asperger Syndrome Diagnostic Scale.

- The child must have behavioral and/or social or communication deficits that require supervision, that impact the ability of the child's family providing care in the home, and that interferes with the child participating in activities in the community;
- Have needs that can be met within the waiver cap of $22,000;
- Waiver eligibility must be re-determined at least annually.

Partnership for Hope Waiver

To be eligible for the PfH Waiver individuals must:

- Be eligible for Medicaid;
- Be determined by regional office to have a developmental disability as defined by Section 630.00 5 (9) of RSMO, 1994;
- Persons do not require residential services and typically are living in the community with family members;
- The individual is at risk of needing ICF/DD institutional services if unable to access waiver services to subsidize care and support provided by the community and family;

- The estimated cost of waiver services and supports necessary to support the person must not exceed $12,000 annually.
- Waiver eligibility must be re-determined at least annually.

Prioritization of Need Categories

The PfH waiver does not use the Division's Prioritization of Need (PON) process as described in the Code of State Regulations (CSR). The PfH waiver has developed a county based Prioritization of Need system. It is divided into "Crisis" and "Priority". If a person falls into the 'Crisis' category they will be served first. If multiple people fall into the 'Crisis' category, the person who has been waiting the longest will be served first. If no one is in the 'Crisis' category then the person waiting the longest under the 'Priority' category will be served first. Each county will determine who falls into what category. The regional offices will only pass the form through to request a PfH waiver slot from central office.

Crisis

Each bullet point in Priority Category has equal weight.

- Health and Safety conditions pose a serious risk of immediate harm or death to the individual or others;
- Loss of Primary Caregiver support or change in caregiver's status to the extent the caregiver can't meet needs of the individual; or
- Abuse, Neglect or Exploitation of the individual.

Priority

Each bullet point in Priority Category has equal weight.

- Individual's circumstances or conditions necessitate substantial accommodation that cannot be reasonably provided by the individual's primary caregiver;
- Person has exhausted both educational and Vocational Rehabilitation (VR) benefits or not eligible for VR benefits and have a need for pre-employment or employment services;
- Individual has been receiving supports from local funding for 3 months or more and services are still needed and the service can be covered by the waiver. Refinancing; or
- Person living in a non-Medicaid funded Residential Care Facility (RCF) chooses to transition to the community and determined capable of residing in a less restrictive environment with access to the PfH.

Exceptions Processes for Division of DD Waivers

The Autism and Community Support Waivers have an annual individual cost cap of $22,000; PfH has an annual individual cost cap of $12,000. If an individual has needs in excess of the cost limit, to ensure health and welfare of the individual an exception may be granted for additional services above the individual cost cap.

If an individual has a change in condition or circumstances that exceed the cost limit, to ensure health and welfare of the individual an exception may be granted for additional services above the individual cost cap.

The service coordinator will revise the ISP to add information regarding the increased need.

The ISP will go to Utilization Review (UR) for approval or denial. Exceptions are granted by Division Director or designee. Refer to Division Guideline for exceptions to the waiver cost caps at: http://dmh.mo.gov/docs/dd/Guideline6.pdf

Section B: Staff Education Definitions

Professional Management

Available in: Comprehensive, Community Support and PfH Waivers only.
Refer to Division Directive on Professional Management at: http://dmh.mo.gov/docs/dd/directives/2040.pdf

Relevant experience may be substituted for degree.
Responsibilities include:

- Staff training and supervision;
- Quality enhancement monitoring;
- Direct plan implementation for individuals as needed;
- Monitoring implementation of outcomes;
- Establishing information collection systems;
- Writing monthly reviews; and
- Oversight/coordination of all the person's programs and services being received.
- Coordinating the development of the ISP (scheduling, facilitation and summary document).

Qualified Developmental Disability Professional is NO LONGER required for the following services: Community Employment, Day Service, Group Home, Individual Supported Living (ISL), Out of Home Respite, and Personal Assistance. The management functions for these services may be carried out by a professional manager, who either has a college degree or relevant experience.

Qualified Developmental Disability Professional (QDDP)

Available in: Lopez and Autism Waivers only.

The following represents the minimum requirements for individuals to be considered Qualified Developmental Disability Professionals:

Psychologist: A person with at least a master's degree in psychology from an accredited school and with at least one year of experience in working directly with persons with mental developmental disabilities.

Physician: A doctor of medicine or osteopathy who has at least one year of experience in working directly with persons with developmental disabilities.

Social Worker: A person who holds a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or a person who holds a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or

another comparable body. The social worker must also have at least one year of experience in working directly with persons with developmental disabilities.

Occupational Therapist: A person who is eligible for certification by the American Occupational Therapy Association or another comparable body and who has at least one year of experience in working directly with persons with developmental disabilities.

Physical Therapist: A person who is eligible for certification by the American Physical Therapy Association or another comparable body and who has at least one year of experience in working directly with persons with developmental disabilities.

Speech Pathologist or Audiologist: A person who is eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the Speech-Language-Hearing Association or another comparable body; or a person who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification. A speech pathologist or audiologist must also have at least one year of experience in working directly with persons with developmental disabilities.

Registered Nurse: A person who is a registered nurse and who has at least one year of experience in working directly with persons with developmental disabilities.

Professional Recreation Staff Member: A person who has a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education and who has at least one year of experience in working directly with persons with developmental disability.

Human Services Professional: A person who has at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation, counseling and psychology) and who has at least one year of experience in working directly with persons with developmental disabilities.

PROVIDER QDDP RESPONSIBILITIES: Whether the provider facilitates the ISP or participates in its development as a member of the interdisciplinary team, the provider QDDP Rev. 08/07 has the following responsibilities:

- Actively participate in the person centered planning proves;
- Provide supervision and training to direct support staff regarding implementation of ISP;
- Design support and teaching strategies, i.e., training plans, teaching methods for implementation;
- Ensure support and teaching strategies are referenced in the ISP;
- Make changes to support/teaching strategies to ensure progress toward achievement of outcomes and action steps;
- Regularly monitor the implementation of the ISP;
- Make necessary changes to the ISP outcomes based on collection of data, direct support feedback and observations of the individual working toward plan outcomes Outcomes may only be changed with the approval of the person, his/her guardian, and other members of the interdisciplinary team;
- Ensure that services and supports are provided as specified in the ISP plan. This includes, at a minimum, one face to face visit to observe the individual receiving supports,

- Provide service coordinator with monthly reports on progress,
- Facilitate opportunities for natural supports,
- Document specific QDDP activities provided to the individual,
- Inform staff about the Missouri Quality Outcomes.

Direct Care Staff

Available in: Comprehensive, Community Support, Autism, Lopez, and PfH Waivers.

Must be 18 years of age and have the following:

- A high school diploma or its equivalent*;
- Current certification in a competency based CPR/First Aid Course;
- Training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;
- Training in the implementation of (*each individual's)* service plan (within one month of employment) (*effective 09/01/07)* and training in a positive behavior support curriculum approved by the Division of DD (within 3 month of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully met the requirements of 9CSR 45-3.070;
- (FOR DAY SERVICE ONLY) One year experience working with people with developmental disabilities, or in lieu of experience, must successfully complete training in the Missouri Quality Outcomes approved by the Division of DD regional office.

- **Exemptions to H.S. diploma/GED requirement:*
- † *Staff without diplomas or GEDs employed by the same provider prior to 7/1/96 will be "grandfathered".*
- † *Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider must document the staff's enrollment in school or GED courses.*
- † *After 7/1/96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee's file.*

Section C: Documentation Requirements

Adequate Documentation

All services provided must be adequately documented in the individual record. The Code of State Regulations, 13 CSR 70-3.030, Section (2) (A) defines —adequate documentation and —adequate medical records as follows: Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the individual to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site

at which the service was rendered, with the exception of in-home services such as personal care, home health, etc.

Documentation

Implementation of services must be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive group home or individualized support living (ISL) and at least quarterly for individuals who live in their natural home. As per 13 CSR 70 – 3.030 (Link: www.sos.mo.gov/adrules/csr/current/13csr/13csr.asp), the provider is required to document the provision of Division of DD Waiver services by maintaining:

- First name, and last name, and either middle initial or date of birth of the service individual;
- An accurate, complete, and legible description of each service(s) provided. This information may be included in daily activity records that describe various covered activities (services) in which the individual participated;
- Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. This may be included in attendance or census records documenting days of service, signed by the provider or designated staff; records indicating which staff provided each unit of service; and documentation of qualifications of staff to provide the service;
- Identify referring entity, when applicable;
- The date of service (month/day/year). This can be included in attendance or census records;
- Start and stop time must be included in the documentation for MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering the service, such as personal assistant. This applies to Developmental Disabilities Waiver services. (e.g., 4:00 – 4:30 p.m.);
- Services that do not have a time factor in completing the service does not require a start and stop time, but would need to have related documentation to verify the service was provided (e.g., invoices for equipment, trip reports for transportation, etc);
- The setting in which service was rendered;
- ISP, evaluation(s), test(s), findings, results, and prescription(s) as necessary;
- Service delivery as identified in the ISP;
- Individual's progress toward the goals stated in the ISP (progress notes). Sources of documentation include progress notes by direct care staff regarding situations (whether good or bad) that arise affecting the individual; and monthly provider summaries noting progress on individual's goals and objectives in their ISP, and overall status of the individual;
- For applicable programs, include invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and staff training records;
- Applicable documentation should be contained and available in the entirety of the medical record.

All providers must follow the above documentation requirements unless otherwise noted in section F of this manual. Any additional requirements for a specific service are also included in this section.

Section D: Self Directed Supports

Self -Directed Supports (SDS) is an option for service delivery for individuals with developmental disabilities who wish to exercise more choice, control and authority over their supports. SDS is founded on the principles of Self-Determination. Under this option the individual or their designated representative has employment and budget authority.

- Employment authority allows the individual or their designated representative to recruit, hire, train, manage, supervise and fire employees;
- Budget Authority allows the individual or their designated representative flexibility over managing a yearly budget allocation. For example, they may request that more services be authorized in one month and less in another or request to change from one approved waiver service to another as long as they stay within the authorized budget.

Self-direction includes six core components: person-centered planning, individual control of budgets, independent support brokerage, financial management services, a backup plan & quality enhancement & improvement.

Self-direction is firmly based in the principal of self-determination.

Self-determination refers to individuals or their designated representatives exercising control over their own lives, working toward achieving individualized life goals, and obtaining the skills and supports necessary to realize their visions for the future to build opportunities and relationships. The premise is that when individuals have control of their resources their quality of life will improve and the overall cost of services will decrease.

The following services may be self-directed in the **Comprehensive, Community Support and PfH Waivers:**
Community Specialist;
Personal Assistant;
Support Broker;

The following services may be self-directed in the **Autism Waiver:**
In Home Respite;
Personal Assistant;
Support Broker;

The following services may be self-directed in the **Lopez Waiver:**
Community Specialist;
In Home Respite;
Personal Assistant;
Support Broker;

The service coordinator will assist the individual or their designated representative in understanding the choice of self-directed supports and transitioning from provider driven to self-directed services. They can also hire a support broker to provide information and assistance in order for them to self-direct their supports.

When an individual chooses to self-direct supports the individual or their chosen representative is the employer.

The Division of DD contracts with a single Vendor Fiscal/Employer Agent (F/EA) Fiscal Management Service (FMS) organization to assist the employer with payroll-related functions. These functions include conducting a background screening of employee candidates, collecting and processing required human resource related forms and information (such as the IRS Form W-4, the US CIS Form I-9 and information necessary to register employees in the state‘s new hire reporting system), collecting and processing employees‘ time sheets, processing employees‘ payroll and the associated federal and state income tax withholding and employment taxes and other related payroll activities (such as issuing annual IRS Forms W-2 and refunding over-collected Medicare and Social Security taxes, as needed).

The method used to determine the individual budget and process are as follows:

- Needs of the individual are identified in the ISP. The individual, along with the planning team, determines how the needs can be best met through natural supports, or paid supports and a budget is drafted to meet the individual’s needs.

- The budget and ISP are reviewed by the Utilization Review (UR) Committee. UR considers the budget request in comparison with the level of funding that is approved for other individuals with similar needs and either recommends the regional director approve the budget or approve the budget with changes.

- The individual is notified in writing of the proposed budget and ISP prior to implementing. The ISP should be signed by the individual or guardian prior to implementation, every attempt is made to obtain written approval and all attempts are documented in the individual’s file. The notice includes appeal rights should an individual disagree with the ISP and budget.

- The written notice includes information on the individual’s right to a fair hearing and offers help with the appeal process. They may first appeal to the regional director. If they are dissatisfied, they have appeal rights through both the Departments of Mental Health and DSS. While individuals are encouraged to begin with the Department of Mental Health's hearing system, they may skip this hearing process and go directly to the DSS, MO HealthNet Division (Single State Medicaid Agency) hearing system.

- Individual/guardians or designated representatives may request changes to budgets as needs change. For example, they may authorize more services be provided in one month and less in another month. Or, if needs increase, they may request additional services. When additional services are requested, the budget must be approved through the UR process. If an increase in service is needed immediately, an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary.

- All regional offices administer the UR process according to state regulation.

- Individuals/guardians or designated representatives served by the Division of DD and providers are provided information on the UR process.

Section E: Organized Health Care Delivery System (OHCDS):

Waiver services may be provided by an Organized Health Care Delivery System (OHCDS) defined in 42CFR447.10. An OHCDS must provide at least one Medicaid service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. County Boards for Developmental Disabilities who provide TCM may be enrolled with DSS, as a waiver OHCDS and may bill waiver services under the OHCDS provider number.

When OHCDS arrangements are used, all of the following apply:

- The OHCDS must have a written contract with any subcontractor who will provide waiver services;
- All subcontractors providing waiver services must meet applicable provider qualifications;
- A qualified provider cannot be forced to contract with an OHCDS, but may enroll directly with the state Medicaid agency, MO HealthNet;
- Waiver individuals must be able to select any qualified provider who has contracted with the OHCDS, or select a provider that is not contracted with the OHCDS but has enrolled directly with MO HealthNet;
- The OHCDS must maintain all documentation of services furnished by the subcontractor.

The OHCDS may bill only for the cost of waiver services and must pass the reimbursement to the subcontractor, and may not retain excess payments and divert them to other uses. The amount billed to MO HealthNet cannot include administrative costs of the OHCDS.

Section F: Service Definitions

Assistive Technology

Available in: Comprehensive, Community Support and PfH Waivers only.

This service includes Personal Emergency Response Systems (PERS), Medication Reminder Systems (MRS) and other electronic technology that protects the health and welfare of an individual. This service may also include electronic surveillance/monitoring systems using video, web-cameras, or other technology. However, use of such systems may be subject to human rights review. Assistive technology shall not include household appliances or items that are intended for purely diversional or recreational purposes. Assistive technology shall be evidenced based, and shall not be experimental.

Personal Emergency Response System (PERS) is an electronic device that enables an individual at high risk of institutionalization to secure help in an emergency that is connected to a device and programmed to signal a response center once the help button is activated. The response center is staffed with trained professionals. The service is limited to those who live alone, live with others who are unable to summon help, or who are

alone for significant portions of the day, have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision.

A medication reminder system (MRS) is an electronic device programmed to provide a reminder to an individual when Medications are to be taken. The reminder may be a phone ring, automated recording or other alarm. This device is for individuals who have been evaluated as able to self administer medications with a reminder. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser. Medications must be set-up by an RN or professional qualified to set-up medications in the State of Missouri.

All electronic device vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by individuals who are visually or hearing impaired or physically disabled.

Any assistive technology device must not interfere with normal telephone use.

The PERS and MRS must be capable of operating without external power during a power failure at the individual's home in accordance with UL requirements for home health care signaling equipment with stand-by capability and must be portable.

An initial installation fee is covered as well as ongoing monthly rental charges and upkeep and maintenance of the devices.

Any assistive technology devices authorized under this service shall not duplicate services otherwise available through state plan.

MRS and PERS are just two of many different types of assistive technology. More examples of assistive technology that can enable people to be less dependent upon direct human assistance include but are not limited to electronic motion sensor devices, door alarms, web-cams, telephones with modifications such as large buttons, telephones with flashing lights, phones equipped with picture buttons programmed with that person's phone number, devices that may be affixed to a wheelchair or walker to send an alert when someone falls (these may be slightly different than a PERS) text-to-speech software, devices that enhance images for people with low vision, intercom systems.

Costs are limited to $3,000 per waiver year, per individual. For the Comprehensive and the Community Support waivers, the waiver year runs July 1st through June 30th; the PfH waiver year runs October 1st through September 30th.

Provider Requirements:

Agency- Provider type must have a valid DMH contract to provide this service. The company shall be registered and in good standing with the Secretary of State Office.

Other Standard:

The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by backup power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS individual's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

Assistive Technology:

- Medicaid procedure code: Assistive Technology A9999
- Unit of Service: 1 job/item
- Maximum Units of Service: 1/month

Assistive Technology Documentation:

The provider must maintain all documentation as per the requirements set forth in Section C of this manual. Assistive Technology documentation includes but not limited to itemized invoices documenting the items purchased/rented and installed, and monthly service rates/expenses associated with device operation, upkeep and maintenance.

Behavior Analysis Service

Available in: Comprehensive, Community Support, Autism, and PfH Waivers.

This service is designed to help individuals demonstrating significant deficits (challenges) in the areas of behavior, social, and communication skills acquire functional skills in their homes and communities and/or to prevent hospitalizations or out-of-home placements. Behavior Analysis services may be provided to assist a person or persons to learn new behavior directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior.

- An individual's Behavior Analysis Services are based on the Functional Behavioral Assessment (FBA) which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations;
- The plan should describe strategies and procedures to generalize and maintain the effects of the behavior support plan and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan;
- The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session;
- The service shall include monitoring of data from continuous assessment of the individual's skills in learning, communication, social competence, and self-care guide to the scope of the individual support plan, which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery;
- Data should be displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph. The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre-intervention levels of behavior, and strategy changes;
- Performance based training for parents, caregivers and significant others in the person's life are also part of the behavior analysis services if these people are integral to the implementation or monitoring of the plan.

Senior Behavior Consultant and Behavior Intervention Specialist may be authorized in conjunction with a Functional Behavioral Assessment (FBA), which is a separate service, cost and code. The purpose of the FBA is to gather information in the form of data from descriptive assessment, observation and/or systematic manipulation of environmental variables, written and oral history of the individual. The information from the FBA should lead to identification of possible controlling and contributing variables, and possible proactive, preventative and reactive strategies for the identified challenges of the individual referred for Behavior Analysis Services.

NOTE: The Behavior Analysis Service is not intended to be an ongoing service. The following guidance shall be used when submitting authorizations to the UR Committee: Initial authorization for Behavior Analysis Service may not exceed 180 days,

- One subsequent authorization for Behavior Analysis Service may be approved, not to exceed an additional 90 days;
- Additional authorizations for Behavior Analysis Service must be approved by the Division Deputy Director or Assistant Director;
- Behavior Analysis Service may not be authorized concurrent with Applied Behavior Analysis;

Senior Behavior Consultant

The service consists of design, monitoring, revision and/or brief implementation of 1:1 behavioral interventions described in the individual's behavior support plan.

The service is designed to be utilized for situations involving complex behavioral issues such as severe aggression or self injury or when multiple behavioral challenges have been identified, many interventions have been unsuccessful or the challenges have a long history of occurrence. The Behavior Analysis service provides advanced expertise and consultation at critical points in the service delivery to achieve specific ends in the service delivery process such as assess a complex problem behavior, problem solve the lack of progress, or regression in the intervention. Ongoing management of behavior analysis services might generally be provided by the Behavior Intervention Specialist. Evaluation of these data is used to revise the individual's support plan and accompanying services to ensure the best outcome for the individual. Implementation of the behavior support plan may occur with all levels of this service, i.e., with the Behavior Intervention Specialist, with personal assistants, and/or with the family members.

Behavior Intervention Specialist

Provides ongoing management of behavior analysis services. In more complex or involved situations the Behavior Intervention Specialist is responsible for managing the direct implementation of the recommendations and strategies of a Behavior Analysis service, participating in the development of the behavior support plan and document as a team participant. In these more complex cases the Behavior Intervention Specialist serves as a "bridge" between the Senior Behavior Consultant and the other service providers and family and supports of the individual receiving services. In cases which do not require the advanced services of a Senior Behavior Consultant the Behavior Intervention Specialist may provide the Functional Behavioral Assessment and Behavioral Services without the oversight of a Senior Behavior Consultant except as required by licensure law and professional standards (Board Certified Assistant Behavior Analyst [BCABA] practice standards require supervision by a Board Certified Behavior Analyst [BCBA]). At a minimum, the Behavior Intervention Specialist will provide face-to-face in-home training on the behavior support plan to families and/or primary caregivers who have responsibility for implementing the behavior support plan in the home or community setting. This shall include training for meals, hygiene, school and/or community activities, and evenings and weekends noted in the behavior support plan as particularly challenging. Ongoing management of a behavior support plan is a key role for a Behavior Intervention Specialist. Ongoing management involves collecting and analyzing data for the effectiveness of the behavior support plan, fidelity of implementation of the behavior support plan and reliability of the data, adjustment or revision of the strategies identified in the behavior support plan, training caregivers and family members on the implementation of the behavior support plan, and on occasion implementation of the behavior support plan when complicated techniques are involved or for short trial periods to determine if the plan is viable and as part of the training of the main implementers for the behavior support plan.

Functional Behavioral Assessment

FBA is a comprehensive and individualized strategy to identify the purpose or function of an individual's behavior, develop and implement a plan to modify variables that maintain the problem behavior, and teach appropriate replacement behaviors using positive interventions. The FBA which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations. The FBA provides information necessary to develop strategies and recommendations to proactively address the challenging behaviors through skill development,

prevention of problem situations and contributing reactions and interactions with significant persons in the life of the individual. These recommendations and strategies are more thoroughly delineated in the person's behavior support plan.

The process of the FBA includes gathering a written and oral history of the individual including data, interview of significant individuals who have been involved with the person during times of challenging behaviors as well as times when the person does not have challenging behaviors, observation of the person in a variety of situations, data collection and review, and for the most complex behaviors and situations a systematic manipulation of possible controlling and contributing variables. This information gathering process should lead to identification of possible controlling and contributing variables, and possible proactive, preventative and reactive strategies for the identified challenges of the individual referred for Behavior Analysis Services.

There will be situations in which an assessment will be needed to determine if other services or if behavior services might be appropriate. Not every instance of assessment will lead to behavioral services. If changes in situations occur, a new assessment may be warranted.

The FBA is a diagnostic assessment. Behavior analysts (including both senior consultant and behavior intervention specialist) conducting the FBA must be licensed in the State of Missouri (20 CSR 2063-4.005; 20 CSR 2063-5.010).

While information included in the FBA may be used to inform the level of care (LOC)assessment, the FBA itself cannot substitute for the LOC assessment. Information included in the LOC assessment may also be reviewed and considered by the behavior analyst while conducting a FBA; however, an LOC assessment cannot substitute for the FBA assessment.

FBA are limited to every two years unless the individual's behavior support plan documents substantial changes: to the individual's circumstances (living arrangements, school, caretakers); in the individual's skill development; in the performance of previously established skills; or in frequency, intensity or types of challenging behaviors. A Behavior Intervention Specialist may under the direction of a Senior Behavior Consultant, conduct the data gathering for a functional assessment; however, the final interpretation and recommendations must be the work of the Senior Behavior Consultant.

This service is not restricted by the age of the individual; however, it may not replace educationally-related services provided to individuals when the service is available under IDEA or other sources covered under an Individualized Family Service Plan (IFSP) through First Steps or otherwise available.

Provider Requirements:

An individual or an agency must have a DMH contract.

Senior Behavior Consultant-Doctorate: Can be provided by an agency or an individual who has a Missouri state license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis as according to RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Senior Behavior Consultant-Masters: Can be provided by an agency or an individual who has a Missouri state license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis as according to RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Behavior Intervention Specialist: Can be provided by an agency or an Individual who has a Missouri state licensure as a Licensed Assistant Behavior Analyst or a licensed professional in psychology, social work or professional counseling with training specific to behavior analysis. RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Behavior Analysis:
Medicaid procedure code(s):

- Senior Behavior Consultant: H2019HO
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day
- Behavior Intervention Specialist: H2019
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/ day
- Functional Behavior Assessment: H0002
    - Unit of Service: 1 assessment
    - Maximum Units of Service: 1 assessment/2 years

Behavior Analysis Documentation:

Behavior Analysis providers must maintain service documentation as described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Behavior Therapy

Available in: Lopez Waiver only.

Behavior Therapy Services provide systematic behavior analysis and assessment, behavior management plan development, consultation, environmental manipulation and training to and for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self direction or community integration, and/or are threatening to require movement to a more restrictive placement. Behavior therapy may also include consultation provided to families, other caretakers, and habilitation services providers. The unit of service is one-fourth of an hour.

All behavior management programs must meet and comply with the current version of "Guidelines and Procedure for the use of Behavior Management Techniques", State of Missouri, Department of Mental Health, Division of Developmental Disabilities.

Behavior Therapy services shall not duplicate other waiver services including but not limited to: Personal assistant, community specialist, and crisis intervention services.

Provider Requirements:

The agency or individual must have a DMH contract.

This service can be provided by an agency or an individual: Behavior Therapy Service-Doctorate: Who has a Missouri state license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis as according to RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224.

This service can be provided by an agency or an individual: Behavior Therapy Service-Masters: Who has a Missouri state license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis as according to RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Working under the supervision of a licensed behavior analysts (master's or Ph.D level) a person with a bachelor's degree from an accredited institution and who is Board Certified Associate Behavior Analysts (BCABAs) and have the Related Missouri state licensure can provide behavior therapy services to address problems and situations in which he or she has received training.

Behavior Therapy:
Medicaid procedure code:

- Behavior Therapy: H0004
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day
- Behavior Therapy, Consultation: H0004
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day

Behavior Therapy Documentation:

Behavior therapy providers must maintain service documentation as described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's service plan. Written data shall be submitted to DMH authorizing staff as required.

Communication Skills Instruction

Available in: Comprehensive and Community Support Waivers only.

Communication Skills Instruction services are intended to train individuals with minimal language skills (MLS) to use systematic communication. Individuals with MLS are deaf persons who know neither English nor American Sign Language (ASL), nor have any other formal communication system. This service is used to help individuals with multiple developmental disabilities communicate with the people around them, a critical skill for community survival and exercising choice and self determination.

Communication Skills Instruction includes both assessment/evaluation and training. An initial assessment of an individual's communication skills is performed to determine the need for instruction. It measures the number of ASL or home signs used; finger spelling capacity; degree of "parroting;" use of gesture, mime, writing on paper; attention span; facial expressions; and consistency in communication with a variety of others, both deaf and hearing. Evaluation of the outcome of the instruction occurs at six month intervals: this includes evaluation of communication skills in social, vocational and leisure situations, behavioral changes, and need for continued instruction and/or other intervention.

Communication Skills Instruction includes teaching a new communication system or language or enhancing a deaf individual's established minimal language skills, based on the formal assessment of communication skills. Instruction sessions typically involve the people who support the deaf individual as well as the individual himself.

This service is a cost effective alternative to placement in an ICF/DD. The unit of service is 15 minutes.

Provider Requirements:

Individual- Must be a certified interpreter. An individual must have a DMH contract.

Communication Skills Specialist:

- Medicaid procedure code: Communication Skills Specialist: H2014
    - Unit of Service: 15 minutes
    - Maximum Unit of Service: 32/day

Communication Skills Specialist Documentation:

Communication Skills Specialist providers must maintain service documentation as described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

<u>Community Employment</u>

Available in: Comprehensive, Community Support and PfH Waivers only.

Community Employment is competitive work in an integrated work setting with on-going support services for individuals with developmental disabilities. The service must be identified in the ISP. Models of community employment may include individual jobs or group such as enclaves (a cluster of jobs in an integrated setting, such as a plant), and mobile crew. Individual and group services are defined separately below.

Individual Community Employment

Community Employment services are delivered in the community at large when seeking employment and in integrated business work settings (including self-employment situations) where the individual with a developmental disability has chosen to become employed. Ongoing support consists of continuous or periodic job skill training as specified in the ISP to enable the individual to perform the work.

Community Employment services may include:

- Individualized job development and placement;
- On-the-job training in work and work-related skills;
- Ongoing supervision and monitoring of the person's performance on the job; and
- Training in related skills needed to obtain and retain employment such as using community resources and public transportation.

Group Employment

Group Employment services are delivered in regular business and industry settings for groups of no more than six (6) workers with disabilities, with written approval from the regional director the group size may be up to eight (8). Examples include enclaves and mobile work crews. The outcome of this service is sustained paid employment.

Group Employment services may include:

- Job development and placement;
- On-the-job training in work and work-related skills;
- Ongoing supervision and monitoring of the person's performance on the job; and
- Training in related skills needed to obtain and retain employment such as using community resources and public transportation.

Additional information about employment services

When individuals are compensated they must be paid in accordance with the United States Fair Labor Standards Act (USFLSA) of 1985.

Personal care/assistance may be a component of employment services, but may not comprise the entirety of the service. Individuals who receive job discovery and preparation services may also receive other day services. An ISP may include two or more types of non-residential services. However, any combination of non-residential services may not be billed during the same period of the day.

Transportation costs are not included in the community employment fee, but specialized transportation is available as a separate service if necessary.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving community employment

services under the waiver will document that the individual was denied benefits by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service (VR), exhausted VR benefits (nine months is the maximum in Missouri), VR does not cover the specific employment service the individual requires, or the person requests supports from a provider that does not participate in VR's system. The service coordinator's documentation of VR's failure to confirm a denial of benefits in writing within 30 days of verbal notification may also serve as evidence of eligibility for community employment services.

FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a community employment program; 2) Payments that are passed through to users of community employment programs; or 3) payments for training that is not directly related to an individual's community employment program.

Provider Requirements:

Providers must have a DMH HCB Medicaid Waiver contract for the provision of community employment services and must have one of the following: Licensed according to 9 CSR 30-5.050, certified according to 9 CSR 45-5.010 certification; or Commission on Accreditation of Rehabilitation Facilities (CARF), Counsel on Quality Leadership (CQL) or Joint Commission accreditation.

Community Employment:

Medicaid procedure code:

- Community Employment, Individual H2023
    - Unit of Service: 15 minutes
    - Maximum units of Service: 32/ day
- Community Employment, Group: H2023HQ
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ day

Community Employment Documentation:

Communication Employment providers must maintain service documentation as described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Community Specialist

Available in: Comprehensive, Community Support, Lopez and PfH Waivers only.

A Community Specialist is used when specialized supports are needed to assist the individual in achieving outcomes in the ISP.

Community Specialist services include professional observation and assessment, individualized program design and implementation and consultation with caregivers. This service may also, at the choice of the individual designated representative, include advocating for the individual, and assisting the individual in locating and accessing services and supports within their field of expertise.

The services of the Community Specialist assist the individual and the individual's caregivers to design and implement specialized programs to enhance self direction, independent living skills, community integration, social, leisure and recreational skills.

This service shall not duplicate other waiver services including but not limited to: Behavior Analysis or Personal Assistant services.

Community Specialist, a direct waiver service, differs in service definition and in limitations of amount and scope from state plan TCM for person with developmental disabilities. In the latter, there are waiver administrative functions performed by a service coordinator through state plan TCM that fall outside the scope of community specialist, such as level of care determination, free choice of waiver and provider, due process and right to appeal. Additionally, Division of DD service coordinators facilitate services and supports, authorized in the ISP, through the regional office utilization review and authorization process.

Provider Requirements:

Providers of community specialist services must have a Bachelors degree from an accredited university or college plus one year experience, or a Registered Nurse (with an active license in good standing, issued by the Missouri State Board of Nursing) or an Associate's degree from an accredited university or college plus three years of experience. The service may be provided by either an individual provider or an employee of an agency. There is an additional individual directed option for that allows the Community Specialist to be an employee of the individual or family.

An individual or an agency must also have a DMH contract.

An agency can be a day service or ISL provider to provide Community Specialist service that are certified by DMH or accredited by CARF, CQL or Joint Commission. An agency can also be a state plan Personal Care Provider; they must have a DMH contract and may be enrolled as a DSS Personal Care provider.

Community Specialist:
Medicaid procedure code:

- Community Specialist: T1016
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/day
- Community Specialist, Self Directed: T1016U2
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/ day

Community Specialist Documentation:

Community Employment providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Community Transition

Available in: Comprehensive Waiver only.

Transition services are one-time, set-up expenses for individuals who transition from an institution (ICF/DD or Title XIX Nursing Home or other congregate living setting) to a less restrictive community living arrangement such as; a home, apartment, or other community-based living arrangement.

Examples of expenses that may be covered include:

- Expenses to transport furnishings and personal possessions to the new living arrangement;
- Essential furnishing expenses required to occupy and use a community domicile;
- Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent;
- Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

Essential furnishings include items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items. Community transition services shall not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversional or recreational purposes such as televisions, cable TV access or VCRs or DVD players.

This service is limited to persons who transition from a Title XIX institutional setting to the waiver. The services must be necessary for the person to move from an institution and the need must be identified in the person's ISP. Total transition services are limited to $3,000 per individual in the process of moving from a Title XIX Institution to the community. A unit of service is one item or expense.

Provider Requirements:

This service can be provided by an individual contractor or an agency.

An agency can be a group home provider or an ISL provider to provide Community Transition service that are certified by DMH or accredited by CARF, CQL or Joint Commission. An agency can also be an agency contractor or a Division of DD regional office.

An individual or an agency must also have a DMH contract.

An individual contractor must have an applicable business license for service provided.

An agency contractor must be in good standing with the Secretary of State and an applicable business license for service provided.

A group home provider and ISL provider must be licensed according to 9 CSR 40-1,2,4,5 or certified according to 9 CSR 45-5.010, CARF, CQL, or Joint Commission accreditation.

Community Transition:
Medicaid procedure code:

- Community Transition: T2038
    - Unit of Service: 1 job
    - Maximum Units of Service: 1/month

Community Transition Documentation:

The provider must maintain all documentation as per the requirements set forth in Section C of this manual. Community Transition documentation includes but not limited to itemized invoices documenting the items purchased.

Counseling

Available in: Comprehensive and Community Support Waivers only.

Counseling Services include goal oriented counseling to maximize strengths and reduce behavior problems and/or functional deficits, which interfere with an individual's, personal, familial, and vocational or community adjustment. It can be provided to individuals and families when the individual is present with the family. This service is not available to children who are eligible for psychology/counseling services reimbursed under the Healthy Children and Youth (EPSDT) program nor adults when state plan psychology services are appropriate to meet the individual's need.

Counseling includes psychological testing, initial assessment, periodic outcome evaluation and coordination with family members, caretakers and other professionals in addition to direct counseling. This service is needed by certain waiver individual whose living arrangement, job placement or day activity is at risk due to maladaptive behavior or lack of adjustment.

The planning team ensures this service does not duplicate, nor is duplicated by, any other services provided to the individual. Counseling is a cost effective alternative to placement in an ICF/DD.

Counseling services are covered under the Medicaid state plan. They may only be covered under the waiver when a prior authorization request has been submitted to and denied by MO HealthNet.

Provider Requirements:

This service can be delivered by an Individual or an agency.

An individual or an agency must also have a DMH contract.

An individual must be a professional counselor by being licensed as a psychologist, counselor or social worker licensed in accordance with RSMo. Chapter 337.

An agency must enroll as a waiver provider employing psychologist, counselor or social worker licensed in accordance with RSMo. Chapter 337.

Counseling Unit:
Medicaid procedure code: Counseling: H0004TG

- Unit of Service: 15 minutes
- Maximum Units of Service: 32/day

Counseling Documentation:

Counseling providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Crisis Intervention

Available in: Comprehensive, Community Support and Lopez Waivers only.

Crisis intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting and includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with developmental disabilities are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises. This service is a cost effective alternative to placement in an ICF/DD.

Specific crisis intervention service components may include the following:

- Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
- Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;

- Developing and writing an intervention plan;
- Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when a individual is physically aggressive or there is concern that the individual may take actions that threaten the health and safety of self and others;
- Assisting the individual with self care when the primary caregiver is unable to do so because of the nature of the individual's crisis situation; and
- Directly counseling or developing alternative positive experiences for individuals who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

Temporary day services as in a crisis drop in center.

Temporary 24 hour care in a crisis bed of a residence.

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker, behavior analyst licensed by the State of Missouri (RSMo. 1994, Chapter 337). Alternately, the supervisor may be employed by the State of Missouri as a psychologist, clinical social worker, behavior analyst or in an equivalent position. All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services.

Crisis teams may be agency based (certified or accredited ISL lead agencies, day service providers, and group homes, or Division of DD regional offices and habilitation centers), or they may stand alone.

Crisis intervention services are expected to be of brief duration (4 to 8 weeks, maximum). When services of a greater duration are required, the individual should be transitioned to a more appropriate services program such as counseling, or respite.

Crisis intervention needs for the eligible person that can be met through state plan, including EPSDT crisis services, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Waiver crisis intervention shall be provided above and beyond any state plan, including EPSDT crisis service that can meet the individual's need.

Provider Requirements:

An agency must have a DMH contract.

A crisis agency; ISL lead agency; day services; or group home provider agency must have a psychologist, counselor or social worker licensed under RSMo Chapter 337 to provide this service.

This service can also be provided by Division of DD regional office or a habilitation center.

Crisis Intervention:

Medicaid procedure code:

- Crisis Intervention, Professional: S9484
    - Unit of Service: Hour
    - Maximum Units of Service: 24/day
- Crisis Intervention, Technical: S9484HM
    - Unit of Service: Hour

Crisis Intervention Documentation:

Counseling providers must maintain service documentation described in Section C of this manual, including detailed progress notes associated with the crisis situation. Written data shall be submitted to DMH authorizing staff as required.

Day Service

Available in: Comprehensive, Community Support, Lopez and PfH Waivers only.

Day services are defined as any activity which enables individuals to achieve or maintain their optimal physical, emotional, and intellectual functioning. Day activities may include assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities and environments are designed to foster the acquisition of skills, greater independence and personal choice. Day services focus on enabling the individual to attain or maintain identified outcomes in their ISP. Coordination activities necessary to implement the individual plan may include family, professionals and others involved with the individual, as directed by the individual and the planning team. May include Activities of daily living (ADLs) and instrumental activities of daily living (IADLs) at the day program site or in the community, and they may be provided individually or in small groups. Day services may be delivered with a staff ratio not to exceed 1:6. The planning team determines the content, site(s) and mode(s) of learning which best meet the needs of each individual. The planning team also assures that day services are coordinated with any therapies the person requires and that the day services do not duplicate, nor are duplicated by, any other services authorized for the individual.

An individual may also receive employment services while also authorized for day services. The employment service provider may also be the day service provider, or may be a different provider depending upon the choice of the individual. Documentation of services provided must clearly distinguish day services from employment services, and may not be billed during the same period of the day.

For employment type activities an individual should use the employment service for job preparation and/ or job discovery since this service would more directly correlates to employment activities and allows for the tracking of employment specific activities.

Day services may not include educational services and may not supplant educational services individuals are entitled to receive. Transportation costs for community integration activities are included in the unit rate for day services, but costs for transporting individuals from and to their residences are not included.

Personal assistant services cannot be provided at the same time as the day service.

Provider Requirements:

Day services agencies must have a DMH contract.

The agency will either be licensed as stated in 9 CSR 40-1, 2, 9 or certified as stated in 9 CSR 45-5.010 certification; or accredited under CARF, CQL or Joint Commission.

Day Service:
Medicaid procedure code:

- Day Service, On-site, Individual: T2021
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ day
- Day Service, On-site, Group: T2021HQ
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ day
- Day Service, Off-site, Individual: T2021SE
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/ day
- Day Service, Off-site, Group: T2021HQSE
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ day

Day Service Documentation:

Day Service providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Dental
Available in: PfH Waiver only.

- Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth.
- Preventive dental treatment – Examinations, oral prophylaxes, and topical fluoride applications.
- Therapeutic dental treatment – Treatment that includes, but is not limited to, pulp therapy for permanent teeth; restoration of carious permanent teeth; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.

Service Limitations:

Dental services for individuals under the age of 21 are not covered. Dental services for individuals under the age of 21 may be accessed under the state plan as a Healthy Children and Youth (HCY/EPSDT) benefit.

Dental services through the PfH waiver for adults exclude the following:

- Any service that may be covered under the state plan Medicaid program:
    - This includes dental care related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or for treatment of a medical condition without which the health of the individual would be adversely affected. Dental services may be provided to adults as state plan service if dental care is related to: Traumatic injury or jaw, mouth, teeth, or other contiguous (adjoining) sites;
    - Medical conditions related to or for a transplant patient, chemo/radiation therapy patient, systemic diseases; AIDS, other autoimmune diseases, uncontrolled diabetics, paraplegic, quadriplegic and; any other medical condition if left untreated, the dental problems would adversely affect the health of the individual resulting in a higher level of care.

Service unit is one visit, with a maximum of one unit per day. The combined cost of all PfH Waiver services authorized for an individual, including dental services, is limited to $12,000 per year per individual. Dental services, authorized in combination with any other PfH Waiver service, are limited to $12,000 per year for the individual.

Dental Provider Requirements:

Individual Dentist

- Current licensure as a Dentist in the State of Missouri or bordering State;
- Have a DMH contract to provide this service;
- The individual Dentist may be enrolled with MO HealthNet to provide state plan dental care.

Agency-Dental Clinic

- Dentists within the Dental Clinic must have current licensure as a Dentist in the State of Missouri or bordering Stat;
- Licensed Dental Hygienists or Dental Assistants services may be included.

A dentist is not required to enroll with Department of Social Services as a provider of state plan dental care in order to provide dental services through the PfH Waiver.

Dental Unit:

Medicaid procedure code:

- Dental Service: T2025
    - Unit of Service: 1 visit
    - Maximum Units of Service: 1/ day

Service Documentation:

The provider must maintain a plan of treatment and detailed record of all dental procedures by visit. Documentation must meet requirements set forth in 13 CSR 70-3.030.

Employer Provided Job Supports

Available in: PfH Waiver only.

The service allows the Division of DD, designated provider agencies to contract with a business to provide employer provided job supports as a part of the natural workplace. The supports will be provided directly to an individual to assist in the development of positive work-related habits, attitudes, skills and work etiquette directly related to their specific employment, as well as assisting the individual to become a part of the informal culture of the workplace. Employer provided job supports will include orienting the individual to health and safety aspects/requirements of their particular job. Individuals participating in this service are employed by a business and are paid minimum wage or better.

This service differs from Community Employment in that it creates opportunity for services/supports to be provided by the local business' employee where the individual is employed. A peer employee at a business where the person with a developmental disability is employed will have a better understanding of the businesses culture, the organizational structure, and the informal culture than will the developmental disabilities professional who provides Community Employment. Receiving mentoring from a fellow employee increases opportunities for acceptance into and thus success in the workplace community. It is intended to be of short duration.

This service enables a full continuum of job supports that could begin with job preparation, move to job discovery, then community employment with the least intensive support being provided through employer-provided job supports. It is not necessary for an individual to progress along this continuum, however. Depending upon the individual's skills, abilities and needs, identified during the person-centered planning process, they may start at any point; skip steps in the continuum, or transition back into a service where more supports are available.

Throughout the length of a contract, per funding requirements and with the employer's knowledge, the Division of DD or contracted provider performs oversight, just as they do in other waiver services.

This service is over and above the obligations an employer has for an employee without a disability, but does not duplicate nor supplant those provided under the provisions of the Individuals with Disabilities Education Improvement Act, or Section 110 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act.

Service Limitations:

An individual may not receive Job Discovery, Job Preparation, or Community Employment, at the same time they receive Employer Provided Job Supports. Individuals receive Employer provided job supports services during their first six months of employment. Reimbursement may be extended up to 12 months on the job. After the first six months, the contract is reduced to a lower stabilization rate based on job support intervention needed.

Employer Provided Job Supports Provider Requirements:

Must have a DMH contract; to qualify, a description of supports to be provided by the subcontractor must be reviewed and accepted by the personal support team, including the service coordinator and other members designated by the individual, and the individual or his or her legal guardian prior to its execution.
These subcontracts are approved when it is determined that the individual's needs are best met by supports that supplement those provided by industry employees.

The provider must be an employer that is registered with the Missouri Secretary of State as a business in good standing.

Employer Provided Job Support:
Medicaid procedure code:

- Employer Provided Job Support Service: H0038
  - Unit of Service: 15 minutes
  - Maximum Units of Service: 32 units/day

Service Documentation:

Documentation must meet requirements set forth in 13 CSR 70-3.030.

Environmental Accessibility Adaptations

Available in: Comprehensive, Community Support, Lopez, Autism and PfH Waivers**.**

Those physical adaptations required by the ISP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the community and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual, but shall exclude adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. Adaptations may be approved for living arrangements (houses, apartments, etc.) where the individual lives, owned or leased by the individual, their family or legal guardian. These modifications can be to the individual's home or vehicle.

All adaptations must be recommended by an occupational or physical therapist. Plans for installation must be coordinated with the therapist to ensure adaptations will meet the needs of the individual as per the recommendation. The service provider must document the identity of the PT or OT, including full name and Missouri license number. All services shall be provided in accordance with applicable state or local building codes.

Costs are limited to $7,500 per year, per individual for the Comprehensive, Community Support and PfH Waivers. Costs are limited to $5,000 per year, per individual for the Lopez and Autism Waivers. The annual

limit corresponds to the waiver year, which begins July 1st and ends June 30th for the Comprehensive, Community Support, and Autism Waivers. The annual limit corresponds to the waiver year which begins October 1st and ends September 30th each year for Lopez and PfH Waivers.

Provider Requirements:

This service can be provided by an individual or an agency. Both an individual and an agency must have a DMH contract and must have an applicable business license and meet applicable building codes for the service they provide.

Environmental Accessibility Adaptations:
Medicaid procedure code:

- Environmental Accessibility Adaptations: S5165
    - Unit of Service: I job
    - Maximum Units of Service: 1/month

Environmental Accessibility Adaptations Documentation:

The provider must maintain all documentation as per the requirements set forth in Section C of this manual. Environmental Accessibility Adaptations documentation includes but not limited to itemized invoices documenting the items purchased.

Group Home

Available in: Comprehensive Waiver only.

Group home services provide care, supervision, and skills training in activities of daily living, home management and community integration. The services are provided to groups of individuals in group homes, residential care centers and semi-independent living situations (clustered apartment programs) licensed or certified by DMH Licensure, certification and accreditation all meet the requirements of 45 CFR Part 1397 for board and care facilities. A unit of service is one day (24 hours).

Group Homes are owned and operated by public or private agencies under contract with the DMH Division of DD.

Group Homes are paid a per-diem rate for each individual which covers:

- Staff intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, money management and household responsibilities. Also included are the salary, benefits, and training costs of direct program staff, supervisory staff, and purchased personnel who provide services in these areas;
- Habilitation supplies and equipment that are not specifically prescribed for one individual;
- Necessary staff supervision up to 24-hours a day; and
- Agency administration for habilitation services.

Group Homes must maintain staffing per resident ratios according to requirements detailed in 9 CSR Chapter 40.

In some cases, individual transportation is included in the rate, when the facility is equipped to routinely provide rides to day service provided at a stand-alone licensed or day service provider, which is not physically connected to the individual's residence or to community integration, etc. The DMH regional offices assure no duplication in payment for this service.

The service excludes the following:

- Services, directly or indirectly, provided by a member of the individual's immediate family;
- Routine care and supervision which would be expected to be provided by a family or group home provider;
- Activities or supervision for which a payment is made by a source other than Medicaid; and
- Room and board costs.

Provider Requirements:

This service can be provided by a Community Residential Facility or a Semi- Independent living arrangement. The agency must have a DMH contract.

A Community Residential Facility and a Semi-Independent Living arrangement shall be licensed according to 9 CSR 40-1, 2, 4, 5 or they will be certified according to 9 CSR 45-5.010; or they may be accredited by CARF, CQL or Joint Commission.

Group Home:
Medicaid procedure code:

- Group Home: T2016HQ
    - Unit of Service: Day
    - Maximum Units of Service: 1/Day
- Group Home Intensive Rate: T2016HQ
    - Unit of Service: Day
    - Maximum Units of Service: 1/ Day
- Group Home Transition: T2016HQ
    - Unit of Service: Day
    - Maximum Units of Service: 1/ Day

Group Home Documentation:

Group Home providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Host Home (Shared Living)

Available in: Comprehensive waiver only.

A Host Home is a private home, licensed or certified by the Division of DD, where a family accepts the responsibility for caring for up to three individuals with developmental disabilities. A Host Home offers a safe and nurturing home by giving guidance, support and personal attention. The provider plays an active role in the individual's team and the collaborative development of an ISP. The ISP is based on the team's knowledge of the individual's personal challenges, strengths, skills, preferences and desired outcomes. The ISP provides guidelines and specific strategies that address the person's needs in the social, behavioral and skill areas and is designed to lead to positive lifestyle changes. Living in a home environment presents daily opportunities to acquire and use new skills. The host family helps the individual participate in family and community activities and facilitate a relationship with the person and his/her natural family and the general community. They help the person learn and use community resources and services as well as participate in activities that are valued and appropriate for the person's age, gender and culture. The provider ensures that the person's identified health and medical needs are met and comply with licensure or certification regulations of the Division of Developmental Disabilities.

A single family host home may be licensed by and directly contract with the DMH, or the host family may be directly employed by or under contract with an agency licensed by and under contract with DMH to provide host home services.

Host Home services include the following:

a) Basic personal care and grooming, including bathing, care of the hair and assistance with clothing;
b) Assistance with bladder and/or bowel requirements or problems, including helping the individual to and from the bathroom or assisting the individual with bedpan routines;
c) Assisting the individual with self-medication or provision of medication administration for prescribed medications, and assisting the individual with, or performing health care activities ;
d) Performing household services essential to the individual's health and comfort in the home (e.g., necessary changing of bed linens or rearranging of furniture to enable the individual to move about more easily in his/her home);
e) Assessing, monitoring, and supervising the individual to ensure the individual's safety, health, and welfare;
f) Light cleaning tasks in areas of the home used by the individual;
g) Preparation of a shopping list appropriate to the individual's dietary needs and financial circumstances, performance of grocery shopping activities as necessary, and preparation of meals;
h) Personal laundry;
i) Incidental neighborhood errands as necessary, including accompanying the individual to medical and other appropriate appointments and accompanying the individual for short walks outside the home; and
j) Skill development to prevent the loss of skills and enhancing skills that are already present that will lead to greater independence and community integration.

Payment to the Host Home is a flat monthly rate to meet the individual's support needs, and is exempt from income taxes. The Host Home will be paid on the basis of intensity and difficulty of care.

Parents of minor children, legal guardians, and spouses cannot be providers for their child, ward, or spouse.

People who live in a Host Home may also receive any other waiver service except for group home, individualized supported living, and personal assistant.

Payments for Host Home services do not include room and board, items of comfort or convenience, or the costs of home maintenance, upkeep, and improvement. Persons who receive Host Home services shall not also receive state plan personal care or adult day health care.

Provider Requirements:

An individual or agency can provide this service. They must have a DMH contract and be licensed according 9 CSR 40-6.010-6.114 or certified according to 9 CSR 45-5.010 -.060. They can also be accredited through CARF, CQL, or Joint Commission.

Host Home:
Medicaid procedure code:

- Host Home(Shared Living): S5136
    - Unit of Service: Day
    - Maximum Units of Service: 1/ Day

Host Home Documentation:

Host Home providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Individualized Supported Living

Available in: the Comprehensive Waiver only.

ISL is characterized by creativity, flexibility, responsiveness and diversity. ISL living enables people with disabilities to be fully integrated in communities. ISL services provide individualized supports, delivered in a personalized manner, to individuals who live in homes of their choice. Individuals receiving ISL supports may choose with whom and where they live, and the type of community activities in which they wish to be involved.

Individualized Supported Living reflects these principles:

a) People live and receive needed supports in the household of their choice which might include their family home, an apartment, condominium, or house in settings typical of people without disabilities. The selected housing should represent an adequate standard of living common to other citizens, allowing for reasonable protection and safety.

b) Personal preferences and desires of those served are respected. Personal autonomy and independence are promoted. Individuals receiving services lead the planning, operation, and

evaluation of services. The individual's self-direction and control leading toward self-governance are maximized through services rendered.

c) Existing resources and natural supports, paid and unpaid, are maximized from the community at large.

d) Training focuses on acquiring functional, useful skills within the community. Services minimize the need for skill transfer by providing training in the environment in which the skills are required.

e) Services are "outcome" focused, addressing the quality of life being experienced in the present life style and not in the potential future implied by skill development/attainment.

f) Services are provided based on individual needs not predicated on inflexible restrictions of specific funding mechanisms.

g) Service goals are directed toward participation in the life of one's own community. As with any other citizen, this involves individual participation in civic activities and joining community organizations assuming those roles which are valued by the community.

If individuals choose to live with housemates, no more than four (4) individuals receiving ISL services may share a residence. Individuals receiving ISL services and sharing a home with housemates shall each have a private bedroom. Couples sharing a home where one or both of the couple receives ISL services may share a bedroom if they so choose.

This service provides assistance and necessary support to achieve personal outcomes that enhance an individual's ability to live in and participate in their community. ISL services and supports are individually planned and budgeted for each person served. Services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. ISL services may also include assistance with activities of daily living and assistance with instrumental activities of daily living, depending upon the needs of the individual. Services may include up to 24 hours of support including a combination of habilitation and/or personal support as specified in his/her ISP. Each resident in the home has free choice of provider and is not required to use the same ISL provider chosen by their housemates.

The residence (house or apartment) is a private dwelling, not a licensed facility and must be owned or leased by at least one of the individuals residing in the home and/or by someone designated by one of those individuals such as a family member or legal guardian.

Reporting Reduction in Services:

In accordance with the lead agency's DMH Purchase Of Service (POS) Waiver contract, when the lead agency delivers less than the hours and/or cost approved on a budget, the lead agency must report the reduction to the regional office within the month of service or the following month and the regional office either adjusts the monthly budget amount prospectively or approves the variance in writing. Variances of five percent or more require approval by the director or the director's designee.

ISL budgets include the following:
Direct Support, which includes:

- Direct Support Staff

Professional management, responsible for:

- Staff training and supervision;
- Quality enhancement monitoring;
- Direct plan implementation for individuals as needed;
- Monitoring implementation of outcomes;
- Establishing information collection systems;
- Writing monthly reviews;
- Oversight/coordination of all the person's programs and services being received; and
- Coordinating the development of the ISP (scheduling, facilitation and summary document);
- Travel.

Back-up and safety net supports, which include:

- Maintenance of a phone number which will be answered 24 hours and to assure a regular point of contact for the person supported;
- Provide a back-up plan should other supports fail to materialize as planned; and
- Assuring communication regarding changes in the person's life (health, behavior, employment, etc.), with those important to the individual, including, but not limited to: Family/guardians, educational staff, employer, day service, case manager, physicians, etc.

Monthly Registered Nurse oversight.

Administrative costs.

No payment is made for supports provided, directly or indirectly, by members of the individual's immediate family. Immediate family, for purposes of ISL services, includes parent, child, sibling, spouse or legal guardian. Because the ISL service includes assistance with activities of daily living and assistance with instrumental activities of daily living, people who use ISL will not also receive state plan personal care.

Individuals who receive ISL services shall not receive waiver personal assistant services at their home but may receive this service outside the home as long as it is not included in the ISL budget. Individuals who receive ISL services may also receive day service, behavior analysis, community employment, crisis intervention, etc. and other waiver services that are identified as needs through the person centered planning process as long as there is no duplication with the ISL service and is not included in the ISL budget.

Provider Requirements:

ISL services may be provided by an agency with a DMH contract.

The provider shall be licensed according to 9 CSR 40-1, 2, 4, 6, certified according to 9 CSR 45-5.010 or accredited by CARF, CQL, or Joint Commission.

Individual Supported Living:
Medicaid procedure code:

- Individual Supported Living: T2016
    - Unit of Service: Day
    - Maximum Units of Service: 1/ Day

Individual Supported Living Documentation:

ISL providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

In-Home Respite

Available in: Comprehensive, Community Support, Lopez and Autism Waivers only.

In-home respite care is provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those persons normally providing the care. To be eligible for in-home respite care, the persons who normally provide care to the individual must be other than formal, paid caregivers. This service is not delivered in lieu of day care for children nor does it take the place of day services programming for adults. While ordinarily provided on a one-to-one basis, in-home respite may include assisting up to three individuals at a time. The only limitation on total hours provided is that they be necessary to avoid institutionalization and remain within the overall cost effectiveness of each ISP. The service is provided in the individual's place of residence. If the service includes overnight care, it must be provided in the individual's place of residence.

A unit of service is 15 minutes or one day. The only limitation on total hours provided is that they be necessary to avoid institutionalization and remain within the overall cost effectiveness of each ISP.

Provider Requirements:

This service can be provided by an individual or an agency.

A provider of this service must have a DMH contract and shall not be the individual's spouse; the parent of a minor child (under age 18); nor the legal guardian.

An independent contractor must have a valid Missouri State professional license such as RN or LPN.

An agency can be a day service, ISL or a group home provider to provide in-home respite service that are licensed according to 9 CSR 40-1,2,4,5 and 9 CSR 40-1,2,4,7 certified according to 9 CSR 45-5.010 or accredited by CARF, CQL or Joint Commission. An agency may also be enrolled as a DSS state plan personal care provider. The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the ISP.

In-Home Respite:
Medicaid procedure code:

- In-Home Respite, Day: S5151
    - Unit of Service: Day
    - Maximum Units of Service: 1/ Day
- In-Home Respite, Individual: S5150
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 40/ Day
- In-Home Respite, Group: S5150HQ
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 40/ Day

In-Home Respite Documentation:

In-Home Respite providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Job Discovery

Available in: Comprehensive, Community Support, and PfH Waivers only.

Job discovery services include but are not limited to the following: Volunteerism, self-determination and self-advocacy (assisting an individual in identifying wants and needs for supports and in developing a plan for achieving integrated employment), job exploration, job shadowing, informational interviewing, labor market research, job and task analysis activities, employment preparation (i.e. resume development, work procedures), and business plan development for self-employment. Job discovery is intended to be time-limited. The initial discovery process should not exceed a three month period and will result in the development of a career profile and employment goal or career plan. Additional monthly increments must be preauthorized by the Division of DD.

If it becomes clear that competitive integrated employment is not a reasonable goal and the individual does not plan to move forward toward competitive integrated employment then other supports and services which are designed to continue on a long term basis should be considered.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving job discovery and preparation services under the waiver will document that the individual was denied benefits by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service (VR), exhausted VR benefits (nine months is the maximum in Missouri), VR does not cover the specific employment service the individual requires, or the person requests supports from a provider that does not participate in VR's system. The service coordinator's documentation of VR's failure to confirm a denial of benefits in writing

within 30 days of verbal notification may also serve as evidence of eligibility for job discovery and preparation services.

When individuals are compensated they must be paid in accordance with the United States Fair Labor Standards Act (USFLSA) of 1985.

Services may be provided in a community workplace setting or at a licensed, certified or accredited facility of a qualified job discovery and preparation service provider.

Job discovery is intended to be time-limited. The initial discovery process should not exceed a three month period and will result in the development of a career profile and employment goal or career plan.

Provider Requirements:

This service can be provided by an agency that has a DMH contract.

The Community Employment Provider shall be licensed according to 9 CSR 30-5.050; certified under 9 CSR 45-5.010; or accredited by CARF, CQL or Joint Commission.

Day service provider shall be certified under 9 CSR 45-5.010; Accredited by the CARF in the area of Personal, Social and Community Services; or accredited by CQL or Joint Commission.

Job Discovery:
Medicaid procedure code:

- Job Discovery, Individual, On-site: T2019
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day
- Job Discovery, Individual, Off-site: T2019SE
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day

Job Discovery Documentation:

Job Discovery providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Job Preparation

Available in: Comprehensive, Community Support, and PfH Waivers only.

Job preparation services provide training and work experiences intended to teach an individual the skills necessary to succeed in paid community employment. Skill training may include volunteerism, following directions, focusing on tasks, completing tasks, achieving productivity standards and quality results, responding appropriately to supervisors/co-workers, attendance and punctuality, problem solving, safety,

mobility, or short term work trials. Training may also address workplace social skills necessary for successful community employment such as appropriate work place attire, hygiene, and interaction with co-workers and supervisors, acceptable work behaviors and other skills such as accessing transportation and connecting to community resources as it relates to obtaining employment. This service should be a pathway towards individualized employment and is dependent on individuals demonstrating progress towards employment over time.

Services may be provided on site or off site in the community. Group Job Preparation service may include serving up to six (6) individuals at a time; however, with written approval from the RO director Job Preparation may serve up to eight (8) individuals.

Transportation costs for Job Preparation services are included in the unit rate, but costs for transporting to and from the residence are not included.

Job preparation services must comply with 42 CFR §440.180(c) (2) (i). The need for services must be documented in the ISP. Services must be primarily habilitation in nature.

This service is limited to a two year period.

Provider Requirements:

This service will be provided by an agency with a DMH contract.

The Community Employment Provider shall be licensed according to 9 CSR 30-5.050; certified under 9 CSR 45-5.010; or accredited by CARF, CQL or Joint Commission.

Day service provider shall be certified under 9 CSR 45-5.010; Accredited by the CARF in the area of Personal, Social and Community Services; or accredited by CQL or Joint Commission.

Job Preparation:
Medicaid procedure code:

- Job Preparation, On-site, Individual: H2025
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day
- Job Preparation, On-site, Group: H2025HQ
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day
- Job Preparation, Off-site, Individual: H2025SE
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/ Day
- Job Preparation, Off-site Group: H2025HQSE
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day

Job Preparation Documentation:

Job Preparation providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Occupational Therapy

Available in: Comprehensive, Community Support, and PfH Waivers only.

Occupational therapy requires prescription by a physician and evaluation by a certified occupational therapist (OT) or certified occupational therapeutic assistant (COTA) under the supervision of an OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. It may also include therapeutic activities carried out by others under the direction of an OT or COTA. Examples are using adaptive equipment, proper positioning and therapeutic exercises in a variety of settings.

The service provider must document the identity of the OT, including full name and Missouri license number. Occupational therapy is covered under the Medicaid state plan for children and youth under the age of 21, so waiver OT is only for people age 21 and over.

Occupational therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Occupational therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first for persons before Developmental Disabilities Waiver occupational therapy is provided.

Provider Requirements:

This service may be provided by an individual or an agency that has a DMH license.

An individual must be certified according to Certified per RSMo 1990 334.735—334.746 as Occupational Therapist by AOTA or registered as a COTA. An Occupational therapist must be either certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA). Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT on a periodic, routine and regular basis.

Agency employing licensed occupational therapists and may also employ registered COTA's supervised by licensed occupational therapists who are certified according to RSMo 1990 334.735—334.746 as Occupational Therapist by AOTA or registered as a COTA. An Occupational therapist must be either certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA). Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT on a periodic, routine and regular basis.

Occupational Therapy:
Medicaid procedure code:

- Occupational Therapy: 97535
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 8/ Day
- Occupational Therapy, COTA: 9753
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 8/ Day
- Occupational Therapy, Consultation: 97535
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 8/ Day

Occupational Therapy Documentation:

Occupational Therapy providers must maintain service documentation as described in Section C of this manual.

Out of Home Respite

Available in: Comprehensive, Community Support, Lopez and Autism Waivers only.

Out of home respite is care provided outside the home in a licensed, accredited or certified waiver residential facility, ICF/DD or State Habilitation Center by trained and qualified personnel for a period of no more than 60 days per year. The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, service coordinator, and any other parties the individual requests. The purpose of respite care is to provide planned relief to the customary caregiver and is not intended to be permanent placement. FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Out of home respite is limited to no more than 60 days annually.

Provider Requirements:

An agency shall have a DMH contract to provide this service.

A Community Residential Facility shall be licensed according to 9 CSR 40-1, 2, 4, 5 or they will be certified according to 9 CSR 45-5.010; or they may be accredited by CARF, CQL or Joint Commission.

A State-operated ICF/DD may also provide this service in accordance with 13 CSR 15-9.010 and in good standing with DHSS.

Out of Home Respite:
Medicaid procedure code:

- Out of Home Respite, Day: H0045
    - Unit of Service: Day

    - Maximum Units of Service: 1/ Day
- Out of Home Respite: H0045
    - Unit of Service: 1 hour
    - Maximum Units of Service: 24/day

Out of Home Respite Documentation:

Providers of the Out of Home Respite service must maintain attendance records and progress notes. The provider is required to follow procedures set forth under in Section C of this manual.

Personal Assistance

Available in: Comprehensive, Community Support, Lopez, Autism and PfH Waivers.

Personal assistant services include assistance with any activity of ADL or IADL. Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, care of adaptive equipment, meal preparation, feeding, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, cueing and minor problem-solving necessary to achieve increased independence, productivity and inclusion in the community. While ordinarily provided on a one-to-one basis, personal assistance may include assisting up to three (3) individuals at a time. With written approval from the regional director personal assistant services may be delivered to groups of four (4) to six (6) persons when it is determined the needs of each person in the group can be safely met.

Personal assistance may also include general supervision and protective oversight. The personal assistant may directly perform some activities and support the individual in learning how to perform others; the planning team determines the composition of the service and assures it does not duplicate, nor is duplicated by, any other service provided to the individual.

For self-directed supports team collaboration allows the individual's employees to participate in the ISP and to meet as a team to ensure consistency in its implementation. A team meeting also can be convened by the individual or their designated representative for the purposes of discussing specific needs of the individual, the individualized progress towards outcomes, and other related concerns. Team collaboration can be included in the individual budget up to 120 hours per plan year.

For agency-based personal assistant services, team collaboration is included in the unit rate.

Relatives as Providers

Personal assistant services shall not be provided by an individual's spouse, if the individual is a minor (under age 18) by a parent. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit the family unit, is not a household task family members expect to share

or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

In case of a paid family member the ISP must reflect:

- The individual is not opposed to the family member providing services;
- The services to be provided are solely for the individual and not task household tasks expected to be shared with people living in family unit;
- The planning team determines the paid family member providing the service best meet the individual's needs;
- A family member will only be paid for the hours authorized in the ISP and at no time can these exceed 40 hours per week. Any support provided above this amount would be considered a natural support or the unpaid care that a family member would typically provide.

Family is defined as: A family member is defined as a parent, step parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

Family members approved to provide personal assistant services may be employed by an agency or employed by the individual/guardian or designated representative using an approved fiscal management service provider. If the person employs his/her own workers using an approved fiscal management service provider, the family member serving as a paid personal assistant shall not also be the designated representative/common law employer.

Relation to State Plan Personal Care Services

Personal care services under the state plan differ in service definition, in limitations of amount and scope, and in provider type and requirements from personal assistant services under the waiver. When an individual's need for personal assistance is strictly related to ADLs and can be met through the DSS state plan personal care program administered by the Division of Senior and Disability Services (DSDS), he or she will not be eligible for personal assistant services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided.

Developmental Disabilities Waiver personal assistant may be authorized when:

- State plan limits on number of units for personal care are reached and more assistance with ADLs and/or IADLs is needed;
- Person requires personal assistance at locations outside of their residence;
- The individual has behavioral or medical needs and they require a more highly trained personal assistant than is available under state plan;
- When the personal assistant worker is related to the individual;
- When the individual or family is directing the service through the FMS contractor.

When waiver personal assistant is authorized to adults also eligible for state plan personal care, the service coordinator must consult and coordinate the waiver ISP with the DSDS service authorization system.

Personal care services are provided to children with disabilities according to the federal mandates of the Early Periodic Screening, Diagnosis and Treatment program. Personal assistant needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Personal assistant services through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver Personal Assistant service is provided. State plan personal care services for children are coordinated through the Bureau of Special Health Care Needs (BSHCN).

When waiver personal assistant is authorized for children also eligible for state plan personal care, the service coordinator must consult and coordinate with the BSHCN service authorization system.

Non-Duplication of Services

Personal assistant services shall not duplicate other services. Personal assistance is not available to waiver individuals who reside in community residential facilities (Group Homes and Residential Care Centers). Individuals who receive ISL services shall not receive personal assistant services at their home but may receive this service outside the home - as long as not included in the ISL budget.

Personal Assistant Qualifications and Training

Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the ISP.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the regional office or TCM entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the personal assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Medication Administration;
h. Behavioral Intervention Training As needed, due to challenging behavior by the Individual, the assistant will also be trained in behavioral intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. Training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual to be served and indentified by the team.

For SDS the planning team will specify the qualifications and training the personal assistant will need in order to carry out the ISP plan, where/by whom the assistant will be trained, and the source, method and degree of monitoring but not less than quarterly. To the extent they desire, the individual or designated representative will select the personal assistant and carry out training and supervision.

Individual/guardian or designated representative may exempt the following trainings if:

- Duties of the personal assistant will not require skills to be attained from the training requirement;
- The personal assistant named above has adequate knowledge or experience in:
    - CPR and first aid;
    - Medication Administration;
    - Behavioral Intervention Training As needed, due to challenging behavior by the Individual, the assistant will also be trained in behavioral intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
    - As needed, training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
    - Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual to be served and indentified by the team.

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's need for the service as an alternative to institutional care and the overall cost effectiveness of his or her ISP. Personal assistant can occur in the person's home and/or community, including the work place. Personal assistant shall not be provided concurrently with or as a substitute for facility-based day services.

Payment is on a 15 minute, fee for service basis, with different rates for individual and small group services, and, when needed, for enhanced staff qualifications.

Personal assistant services through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver personal assistant service is provided. Children have access to EPSDT services.

Provider Requirements:

This service can be self directed if the individual chooses. For more information regarding self directing this service see the section D.

This service can be provided by an individual or an agency.

A provider of this service must have a DMH contract.

An agency can be a day service or ISL provider to provide personal assistance service that are certified by DMH or accredited by CARF, CQL or Joint Commission. An agency may also be a state plan personal care provider and be enrolled as a DSS personal care provider.

An individual may be an Independent Contractor who has a Missouri State professional license such as RN or LPN.

Employee of individual/family who is 18 years of age; meets minimum training requirements; agreement with Division RO; agreement with individual/designated representative; Planning team will specify the qualifications and training the personal assistant will need in order to carry out the ISP; supervision is provided by the individual, family or a designated support broker in providing service in the home or community consistent with the ISP.

Relative employed by individual/family who is 18 years of age; meets minimum training requirements; agreement with Division of DD regional office; agreement with individual/designative representative; shall not be the individual's spouse; a parent of a minor child (under age 18); a legal guardian; nor the employer of record for the individual. The individual shall not be opposed to the family member providing care. The planning team agrees the family member providing the personal assistant service will best meet the individual's needs. Family members employed by the individual or designated representative are supervised by the individual or a designated representative in providing service in the home or community consistent with the ISP plan. Members employed by an agency are supervised by the agency.

Personal Assistant:
Medicaid procedure code:

- Personal Assistant, Individual, Self Directed: T1019U2
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/ Day
- Personal Assistant, Agency, Contractor: T1019
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/ Day
- Personal Assistant, Group Size 2-3: T1019HQ
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/ Day

Personal Assistant Documentation:

Personal assistant providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's. Written data shall be submitted to DMH authorizing staff as required.

Personal Assistant Services: Specialized Medical/Behavioral

Specialized Behavioral Personal Assistance:

To assist in evaluating the need for specialized behavioral personal assistance the following must have been met:

- The interdisciplinary team has documented efforts to maximize the individual's ability to communicate with others;
- The interdisciplinary team has documented implementation of preventive strategies and outcomes of those strategies;
- The interdisciplinary team has identified and outlined the need to pursue more intensive behavior support strategies in the plan;
- An initial screening for medical, psychiatric or pharmacological causes has been completed, and;
- Prior to approval of funding for specialized behavioral personal assistance the ISP has gone through the local ISP review process and has been reviewed by the Regional Behavior Supports Review Committee to determine the above have been completed.

The specialized behavioral personal assistant *must* adhere to the same requirements as outlined for the Individual Provider Employed by Individual or Family. Additional requirements are as follows:

- Received training and holds current certification on positive behavioral support intervention strategies or Tools of Choice training that is approved by DMH and;
- Agency Degreed Professional Manager has participated and successfully completed a DMH approved Positive Behavior Support Training or Tools of Choice training, and;
- Must be trained on the specific individual's behavior support strategies.

Specialized Medical Personal Assistance:

To assist in evaluating the need for specialized medical personal assistance the following must have been met:

- The interdisciplinary team has identified that the individual's level of care requires either the:
- Direct delivery of care by a licensed medical professional or,
- Training, delegation and periodic supervision of care by a licensed medical professional*.
    - *Licensed Medical Professional as defined by the Nursing Practice Act Chapter 335. RSMo.
- The ISP documents the need and timeline for review of service.

The specialized medical personal assistant *must* adhere to the same requirements as outlined for the Individual Provider Employed by Individual or Family. Additional requirements are as follows:

- Received training related to the individual's medical needs as outlined in the ISP and as prescribed by the physician or advanced practice nurse.
- Received training by a licensed medical professional, demonstrated competency in all instructed procedures and are being delegated the task as determined by the supervising licensed medical professional*. This delegation and individualized instruction is specific to this individual and may not be transferred to other individuals.

All training must be documented and available upon request.

Personal Assistant:
Medicaid procedure code:

- Personal Assistant, Specialized Medical/Behavioral: T1019TG

    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/ Day
- Personal Assistant, Specialized Medical/Behavioral, Self -Directed: T1019TGSE
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/ Day

Personal Assistant Documentation:

Personal assistant providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Physical Therapy

Available in: Comprehensive, Community Support and PfH Waivers only.

Physical Therapy treats physical motor dysfunction through various modalities as prescribed by a physician and following a physical motor evaluation. It is provided to individuals who demonstrate developmental, habilitative or rehabilitative needs in acquiring skills for adaptive functioning at the highest possible level of independence.

Services may include consultation provided to families, other caretakers, and habilitation services providers. Physical therapy services may not be carried out by a paraprofessional. A unit of service is 1/4 hour.

Therapies available to adults under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

The service provider must document the identity of the physical therapist, including full name and Missouri license number.

Physical therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Physical therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver physical therapy is provided. Children have access to EPSDT services.

Provider Requirements:

An individual to provide physical therapy service shall have a DMH contract as well as be licensed per RSMo 1990 334.530--334.625.

Physical Therapy:

Medicaid procedure code:

- Physical Therapy: 97110
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 8/ Day
- Physical Therapy, Consultation: 97110

- Unit of Service: 15 minutes
- Maximum Units of Service: 8/ Day

Physical Therapy Documentation:

Physical therapy providers must maintain service documentation as described in Section C of this manual.

Positive Behavior Support

Available in: Comprehensive, Community Support, Lopez and PfH Waivers only.

This service provides consultation for strategies of Positive Behavior Support Strategies (Universal level supports and Focused teaching and environmental strategies) to and for individuals whose undesirable behaviors are disrupting their progress in habilitation, self direction or community integration and/or are threatening (at increased risk for) to require movement to a more restrictive placement. This service may also include consultation provided to families, other caretakers and habilitation service providers.

Positive Behavior Support strategies described as Universal level supports are those that involve evaluating residential or family systems for general system changes that could promote more positive interactions and behaviors clarify expectations and establish positive expectations or rules, improve recognition of desirable behaviors and reduce problematic interactions by support person that might evoke undesirable behaviors. All persons involved in the system would benefit from Universal level supports.

Focused teaching and environmental strategies supports are required if Universal level supports have been consistently utilized and have not resulted in sufficient change such that the undesirable behaviors are still problematic. Focused supports involve consultation, monitoring and training to establish increased opportunities for teaching and practice of desirable behaviors, group involvement in recognition and practice opportunities such as social skills training groups or establishes a system of coaching and prompting for desirable behaviors in situations that commonly are associated with problem behaviors. The behavior therapist might establish and lead such practice opportunities while coaching support person to continue the practice when the service is discontinued.

This service is not to be provided for development or implementation of behavior support strategies or functional assessment as these services require licensure as a behavior analyst, psychologist, counselor or social worker with specialized training in behavior analysis. The unit of service is one-fourth hour. This is a short term service that is not meant to be on going, the typical duration of service is to be six months or less.

Positive Behavior Support differs from the Behavior Analysis Service in that PBS will require providers with a less involved level of training and experience than BAS.

This is a short term service that is not meant to be on going, the typical duration of service is to be six months or less.

Psychology/Counseling services under EPSDT do not include Positive Behavior Support services.

Provider Requirements:

An agency or an individual must have a DMH contract.

This service can be provided by an Individual or an agency who is a Qualified Positive Behavior Support Professional. A Qualified Positive Behavioral Support Professional is a person with a bachelor's degree with special training, approved by the Division, related to the theory and practice of Positive Behavior Supports for individuals with intellectual and developmental disabilities, or Applied Behavior Analysis and implementation of Person Centered Approaches.

Positive Behavior Support:
Medicaid procedure code:

- Positive Behavior Support: H0004HK
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/Day

Positive Behavior Support Documentation:

Positive Behavior Support providers must maintain service documentation described in Section C of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Professional Assessment and Monitoring

Available in: Comprehensive, Community Support, and PfH Waivers only.

Professional Assessment and Monitoring - A face to face visit to evaluate need and identify appropriate assistance including any special instructions for individuals and their caregivers to reduce the need for routine health professional visits and prevent a higher level of care, which may include limited physical assessments, medication set up, injections, limited diagnosis and treatment, nutritional care plans, nutritional counseling if the nutritional problem or condition is of such a degree of severity that counseling is beyond that normally expected as a part of standard medical management, and nutritional therapy services, not otherwise covered by Medicare or Medicaid state plan services. Any changes in health status are to be reported to the physician and service coordinator as needed. Written reports of the visit are required to be sent to the service coordinator. This service may be provided by a licensed registered professional nurse, or a licensed practical nurse under the supervision of a registered nurse, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of Missouri.

This service must not supplant Medicaid state plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self Management Training available under the state plan and a medical nutrition therapy service prescribed by a physician for Medicare eligible's who have diabetes or renal diseases.

Provider Requirements:

The individual must have a DMH contract.

This service shall be provided by an individual Professional Nurse or Dietician who has a valid State of Missouri license per RsMo Chapter 335., 20 CSR 2200-4.020 in Missouri as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or licensed per RsMo 324.200-324.4.225, 20 CSR 2115-2.020 Dietician.

Professional Assessment and Monitoring:
Medicaid procedure code:

- Professional Assessment and Monitoring, Registered Nurse: T1002
    - Unit of Service: 15 Minutes
    - Maximum Units of Service: 48/ Day
- Professional Assessment and Monitoring, Licensed Practical Nurse: T1003
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/ Day
- Professional Assessment and Monitoring, Dietician: S9470
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/ Day

Professional Assessment and Monitoring Documentation:

Professional Assessment and Monitoring providers must maintain service documentation as described in Section C of this manual.

Specialized Medical Equipment and Supplies (Adaptive Equipment)

Available in: Comprehensive, Community Support, Lopez, Autism and PfH Waivers.

Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the ISP, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, durable and non-durable medical equipment and supplies, and equipment repairs when the equipment, supplies and repairs are not covered under the Medicaid State Durable Medical Equipment (DME) plan. Includes incontinence supplies.

Items reimbursed with waiver funds, shall be in addition to any medical equipment and supplies furnished under the state plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Costs are limited to $7,500 per year, per individual for the Comprehensive, Community Support Waivers and PfH Waivers. Costs are limited to $5,000 per year, per individual for the Lopez and Autism Waivers. The annual limit corresponds to the waiver year, which begins July 1st and ends June 30th for the Comprehensive, Community Support and Autism Waivers. The annual limit corresponds to the waiver year which begins October 1st and ends September 30th each year for Lopez and PfH Waivers.

Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the

requirement that state plan services must be exhausted before waiver services can be provided. Developmental Disabilities Waiver other specialized equipment, supplies and repairs shall be provided above and beyond any state plan, including EPSDT, equipment, supplies, and repair service that can meet the individual's needs. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.

Provider Requirements:

This service can be provided by an agency that is registered and in good standing with Missouri Secretary of State, has a DMH Contract and must be enrolled with Medicaid as a state plan DME Provider.

Specialized Medical Equipment and Supplies:
Medicaid procedure code:

- Specialized Medical Equipment and Supplies: T2029
    - Unit of Service: 1 Job
    - Maximum Units of Service: 1/ Month

Specialized Medical Equipment and Supplies Documentation:

The provider must maintain all documentation as per the requirements set forth in Section C of this manual. Specialized Medical Equipment and Supplies documentation includes but not limited to itemized invoices documenting the items purchased.

Speech Therapy

Available in: Comprehensive, Community Support, and PfH Waivers only.

Speech Therapy is for individuals who have speech, language or hearing impairments. Services may be provided by a licensed speech language therapist or by a provisionally licensed speech therapist working with supervision from of a licensed speech language therapist. The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. The need for services must be identified in the ISP and prescribed by a physician. Speech therapy provides treatment for delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing or use of a hearing aid.

Services may include consultation provided to families, other caretakers, and habilitation services providers. A unit of services is 1/4 hour.

Waiver providers must be licensed by the State of Missouri as a Speech Therapist. The Medicaid Waiver enrolled provider may employ a person who holds a provisional license from the State of Missouri to practice speech-language pathology or audiology. Persons in their clinical fellowship may be issued a provisional license. Clinical fellowship is defined as the supervised professional employment period following completion of the academic and practicum requirements of an accredited training program. Provisional licenses are issued for one year. Within 12 months of issuance, the applicant must pass an exam promulgated or approved by the board and must complete the master's or doctoral degree from an institution accredited by the Council

on Academic Accreditation of the American Speech-Language-Hearing Association in the area in which licensing is sought. Provisionally licensed speech therapists must receive periodic, routine supervision from their employer, a Medicaid waiver enrolled speech therapy provider.

Therapies available to adults under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. Services must be required in the ISP and prescribed by a physician. This service may not be provided by a paraprofessional. The service provider must document the identity of the ST, including full name and Missouri license number.

Speech therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Speech therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first for persons before Developmental Disabilities Waiver speech therapy is provided.

Provider Requirements:

This service shall be provided by a Licensed Speech Therapist per RSMo 1990 345.050 or certified in accordance with provisionally licensed per RSMo 1998 345.022, employed & supervised by licensed speech therapist. The individual also must have a DMH contract to provide this service.

Speech Therapy:
Medicaid procedure code:

- Speech therapy:92507
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 8/ Day
- Speech Therapy, consultation: 92507
    - Unit of Service: 15 Minutes
    - Maximum Units of Service: 8/ Day

Speech Therapy Documentation:

Speech Therapy providers must maintain service documentation as described in Section C of this manual.

<u>Support Broker</u>

Available in: Comprehensive, Community Support, Lopez, Autism and PfH Waivers.

A Support Broker provides information and assistance to the individual or designated representative for the purpose of directing and managing supports. This includes practical skills training and providing information on recruiting and hiring personal assistant workers, managing workers and providing information on effective

communication and problem-solving. The extent of the assistance furnished to the individual or designated representative is specified in the ISP.

A Support Broker provides the individual or their designated representative with information & assistance (I&A) to secure the supports and services identified in the ISP.

A Support Broker provides the individual or designated representative with information and assistance (I &A) to:

- Establish work schedules for the individual's employees based upon their ISP;
- Help manage the individual's budget when requested or needed;
- Seek other supports or resources outlined by the ISP;
- Define goals, needs and preferences, identifying and accessing services, supports and resources as part of the person centered planning process which is then gathered by the service coordinator for the ISP;
- Implement practical skills training (recruiting, hiring, managing, terminating workers, managing and approving timesheets, problem solving, conflict resolution);
- Develop an emergency back-up plan;
- Implement employee training;
- Promote independent advocacy, to assist in filing grievances and complaints when necessary;
- Include other areas related to providing I&A to individuals/designated representative to managing services and supports;

Support Brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED.

The Support Broker must have experience or Division of DD approved training in the following areas:

- Ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the ISP;
- Competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques;
- Understanding of Support Broker responsibilities, of advocacy, person-centered planning, and community services;
- Understanding of individual budgets and Division of DD fiscal management policies.

The planning team may specify any additional qualifications and training the Support Broker will need in order to carry out their duties as specified in the ISP.

Support Broker services do not duplicate service coordination. Support Brokerage is a direct service.

A Support Broker may not be a parent, guardian or other family member. They cannot serve as a personal assistant or perform any other waivered service for that individual. This service can be authorized for up to eight (8) hours per day (32 quarter hour units).

Provider Requirements:

This service can be self directed if the individual chooses. For more information regarding self directing this service see the section D.

An agency and an individual must have a DMH contract.

This service may be self directed or provided by an agency or an individual.

For an agency to provide this service they have to be certified by DMH Certification for ISL or day habilitation; or accredited by CARF/CQL/Joint Commission accredited for ISL or day service that employs qualified Support Brokers.

Individual Support Broker who is Age 18: Meets minimum training requirements; agreement with Division of DD regional office; agreement with individual/designated representative, supervised by individual/designated representative.

Support Broker:
Medicaid procedure code:

- Support Broker, Individual, Self-Directed: T2041U2
    - Unit of Service: 15 Minutes
    - Maximum Units of Service: 32/ Day
- Support Broker, Agency: T2041
    - Unit of Service: 15 Minutes
    - Maximum Units of Service: 32/ Day

Support Broker Documentation:

Support Broker providers must maintain service documentation as described in Section C of this manual.

Temporary Residential Service

Available in: PfH Waiver only.

Temporary Residential Service is care provided outside the home in a licensed, accredited or certified waiver residential facility, ICF/DD or State Habilitation Center by trained and qualified personnel for a period of no less than one day (24 hours), and no more than 60 days per year. The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, service coordinator, and any other parties the individual requests. The purpose of temporary residential is to provide planned relief to the customary caregiver and is not intended to be permanent placement. If the needs of the individual exceed the Partnership for Hope Waiver annual cap or the ISP identifies an ongoing need for out of home services then the planning team would work to transition the individual to another Developmental Disabilities Waiver to meet their needs. FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Staff Requirements:

Must be a qualified direct-care staff as defined in Section A of this manual.

Provider Requirements:

Temporary Residential service providers must have a DMH Home and Community Based Medicaid Waiver contract for the provision of temporary residential and one of the following:

- A valid DMH community residential facility license under 9 CSR 40-1,2,4,5 or certified by the DMH under 9 CSR 45-5.010;
- Accreditation by the CARF, in the area of Community Living Programs; or
- The Council for Quality & Leadership for Persons with developmental disabilities (The Council); or
- Certified ICF/DD and Division of DD Habilitation Centers may be enrolled to provide temporary residential.

Service Limitations:

Temporary Residential may not be provided for a period of less than 1 day (24 hours) and no more than 60 days per year.

Temporary Residential:
Medicaid procedure code:

- Temporary Residential: H0045
    - Unit of Service: Day
    - Maximum Units of Service: One/day

Temporary Residential Documentation:

Providers of the temporary residential service must maintain attendance records and progress notes. The provider is required to follow procedures set forth under in Section B of this manual.

Transportation

Available in: Comprehensive, Community Support, Lopez, Autism, and PfH Waivers.

Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the ISP plan. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan. State plan transportation in Missouri is provided to medical services covered under the state plan, but not to waivered services, which are not covered under the state plan. Transportation is a cost effective and necessary part of the package of community services, which prevent institutionalization.

A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services. Alternatives to formal paid support will always be used whenever possible. A unit is one per month.

State plan transportation under this waiver is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services, which are not covered under the state plan.

Provider Requirements

A transportation provider must be licensed per RSMo. Chapter 302, Drivers & Commercial Licensing and have a DMH contract.

Transportation
Medicaid procedure code:

- Transportation: A0120
    - Unit of Service: Month
    - Maximum Units of Service: 1/ Month

Transportation Documentation

Transportation providers must maintain service documentation as described in Section C of this manual.

Section G: Waiver Assurances

MO Division of DD Quality Management

Quality management is an ongoing process States must implement to ensure a waiver program operates as designed, meets statutory and regulatory assurances and requirements, meets intended outcomes, and identifies enhancement opportunities. The six areas of waiver assurance are:

- **Level of Care (LOC) Determination;**
- **Service Authorization**
- **Qualified Providers;**
- **Health and Welfare;**
- **Administrative Authority; and**
- **Financial Oversight.**

For each of the six areas, the State was required to describe in its quality management strategy, activities or processes related to discovery (monitoring and recording the findings); the entities or individuals responsible for conducting the discovery/monitoring processes; the types of information used to measure performance; and the frequency with which performance is measured. Additional detailed descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery were described through the approved waiver application although they may not be specifically identified in this summary. The following sections include CMS required assurances (bold/italics) and an abbreviated statement of processes the Division of DD has identified to address each component of the six waiver quality management assurances.

Level of Care Determination

Waiver individuals for whom there is reasonable indication that services may be needed in the future are provided an individual level of care evaluation.

- Qualified service coordinators employed by the state and other TCM entities agencies complete LOC evaluations for individuals requesting participation into the waiver.

Enrolled individuals are reevaluated at least annually or as needed.

- At least annually, state and other TCM entities service coordinators conduct LOC reassessments for all individuals to determine continued eligibility for the waiver. The number of new and reassessments resulting in eligibility or ineligibility are tracked and reported on annually.

The process and instruments described in the approved waiver are applied to level of care determinations.

- Division of DD Directive 4.060 outlines the process to review plans of waiver individuals which includes requirements for reviewing LOC.

The state monitors level of care decisions and takes action to address inappropriate level of care determinations.

- Regional office supervisory staff reviews LOC determinations and assessments used to determine LOC for the sample individuals.

Individual Service Plans

ISPs address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

- Division of DD Directive 4.060 -Individual Service Plan Guidelines, Training and Reviews prescribes criteria for developing ISPs that will address necessary supports for health and safety of the part individual.
- Designated TCM staff, from each region of the state and who have received training in and have knowledge of the ISP mandatory components, reviews a sample of ISPs on a quarterly basis to ensure compliance with policies and procedures. The Division's Quality Enhancement Leadership Unit evaluates data from these reviews on a quarterly basis to identify any patterns or trends within regions or the state.
- Regional office UR Committees review ISPs for new individuals and individuals requesting additional services.

The State monitors ISP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of plans of care.

- Division of DD Directive 4.060 establishes the requirement for the person centered planning process and the content of ISPs. Division of DD Directive 4.060 describes the process to ensure compliance with Medicaid waiver.
- Designated TCM staff, from each region of the state and who have received training in and have knowledge of the ISP mandatory components, reviews a sample of ISPs on a quarterly basis to ensure compliance with policies and procedures. The Division's Quality Enhancement Leadership Unit

evaluates data from these reviews on a quarterly basis to identify any patterns or trends within regions or the state.

ISPs are updated/ revised when warranted by changes in waiver individual needs.

- Service coordinators assure each waiver individual has an ISP meeting and a new plan completed each year. Records are reviewed for compliance that all services received are identified in the ISP and that service authorizations are current.

Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the ISP.

- Division of DD approved volunteer advocates and/or family members complete the Missouri Quality Outcomes Measure Survey with randomly selected individuals receiving a Division of DD and/or waiver funded residential and/or day habilitation service.
- Service coordinator meet with individuals to monitor services at prescribed times, or as needed by the individual.
- Annual provider monitoring by the regional office, including evidence that paid services were provided and services authorized were provided.

Individuals are afforded choice between waiver services and institutional care. Individuals are afforded choice between/among waiver services and provider.

- Service coordinators explain and offer choice of waiver services and providers for each individual.
- Service coordinator service monitoring.
- Quarterly Reviews of ISP includes a review of documentation that indicates choices were given for waiver services and provider.

Qualified Providers

- The State verifies on a periodic basis that providers meet required licensing and/or certification standards and adhere to other state standards.
- Division of DD Directive 5.060 outlines the process potential new providers must complete to become an enrolled waiver provider.
- Providers that are certified by the DMH Office of Licensure and Certification are recertified every two years.
- Providers that are accredited provide proof of continued accreditation.
- Division of DD conducts annual provider monitoring to determine if staff meet qualifications.

The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

- Division of DD monitors providers annually to assure they meet qualifications.

The State identifies and rectifies situations where providers do not meet requirements.

- Annually, Division of DD verifies that the provider has met all requirements and has proof of appropriate certification, accreditation, state licensing, or other requirements in order to continue as a qualified waiver provider.

The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

- Division of DD monitors providers annually to assure they meet qualifications.

Health and Welfare Assurance

There is continuous monitoring of health and welfare of waiver individuals and remediation actions are initiated when appropriate.

- Division of DD Directive 3.020 prescribes the frequency of monitoring based on all service(s) that the waiver individual receives.
- Regional office staff reviews information quarterly for patterns or trends of individuals and/or providers. Meetings are held with providers to share information, discuss possible causes and solutions for identified patterns or trends and to develop strategies for systemic improvements.
- The Health Identification Planning System (Residential only) is a medical audit designed to safeguard individuals who need significant supports for optimal health; and assure that those supports are in place through a professional nursing review.
- Residential contract providers contract and/or hire Registered Nurses (RN) to provide appropriate delegation and supervision of unlicensed staff that perform such duties as medication administration and other nursing tasks when applicable.

On an ongoing basis the State identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

- All community providers are required to report any instances of abuse, neglect and exploitation.
- Anytime there is suspected abuse, neglect or exploitation, the local regional office submits a request to the department's investigation unit for investigation. Information from the investigation is collected in the CIMOR Event Management Tracking (EMT) system.
- Regional staff and State Quality Enhancement staff review data from CIMOR –EMT on a quarterly basis to determine any patterns or trends for individuals, providers, and statewide.

Administrative Authority

The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

- DSS retains final approval authority for all decisions made by the operating agency including determinations, policies and procedures. Division of DD as the operating agency implements day to day oversight of operation of the waiver.
- DSS/Division of DD audits records of sample individuals annually. This includes a comprehensive compliance review of assurances the state has made. In addition, the MMAC conduct a financial review of payments made to waiver providers.
- The Division of DD Federal Programs Unit works with the Quality Enhancement Leadership Team and Regional offices to address issues identified, including training targeted to address trends locally or statewide as appropriate.

- Division of DD monitors other TCM entities that provide TCM that supports waiver individuals for compliance with State and Federal laws and regulations, conditions of participation, and assurances. Direct services provided by other TCM entities are subject to the same standards and provisions as other providers.

Financial Accountability Assurance

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

- MMAC Unit contacts providers that billed services for the individuals and requests that documentation of delivered services be provided for review.
- UR Committees review all initial ISP and budgets (and those with increased funding requests) to ensure individual's needs are being addressed and that levels of funding for individuals with similar needs are similar statewide.